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NURSING HOME
PATIENT ABUSE:
Realities & Remedies

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Deputy Attorney General

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NURSING HOME PATIENT ABUSE: Realities & Remedies

TO
Hugh L. Carey, Governor
Robert Abrams, Attorney General
The Legislature of the State of New York
The People of the State of New York

FROM

Edward J. Kuriansky
Deputy Attorney General
for Medicaid Fraud Contrc'

83330

New York State Medicaid-Fraud
Control

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INTRODUCTION

The Office of the Deputy Attorney General for Medicaid Fraud Control has been investigating patient abuse in residential health care facilities for over five years. As a result, this Office has become increasingly aware of recurring systemic problems affecting patient care and of the obstacles to deterring and punishing those who abuse the elderly infirm. We believe, therefore, that it is appropriate at this time to systematically analyze, assess and report the problems and findings noted in the more than 1100 cases investigated to date and to make recommendations based on these findings.

This report will highlight some of the persistent patient care problems that we have found. Examples of poor care and malicious behavior will be described. Much of the conduct that we have uncovered demonstrates the need for New York State to enact legislation imposing criminal liability for acts of patient abuse which are currently unprosecutable. Furthermore, our findings illustrate the urgent need for improved staff training and for a certification program that would ensure the

accountability of nonlicensed aides and orderlies. This report also includes recommendations relating to heat emergencies, fire safety, suicide prevention, medical care, and the use of guardrails and restraints.

Although five years of investigation have presented this Office with a broad picture of patient care problems in the nursing home industry, it must be stressed that this report is not intended as a blanket condemnation of the care and treatment provided in residential health care facilities. Nor do we intend to criticize the efforts of the vast majority of people who work in these facilities. In fact, our investigations indicate that the sick and elderly are diligently cared for by most of these employees. Unfortunately, their excellent work and contribution to society frequently go unreported. We believe that the adoption of the recommendations set forth in this report will greatly assist these dedicated individuals in their efforts to provide the highest quality care to the nursing home patients of New York State.

BACKGROUND

In 1975, Governor Hugh L. Carey directed the formation of the Office of the Special Prosecutor for Nursing Homes, Health and Social Services. Former Attorney General Louis J. Lefkowitz appointed Charles J. Hynes as the first Deputy Attorney General and Special Prosecutor to conduct investigations into all aspects of the nursing home industry with the powers set forth in Executive Law Sections 63(3) and 63(8). The Office's mandate included, as a paramount objective, the investigation of allegations of abuse of nursing home patients. When the Deputy Attorney General's Office was designated in 1978, pursuant to newly enacted federal legislation, as the Medicaid Fraud Control Unit for New York State, it became responsible for investigating allegations of abuse and neglect of patients in all residential health care facilities receiving payments under the state Medicaid plan (42 U.S.C. §1396b(q)(4)). On December 8, 1980, Attorney General Robert Abrams appointed Edward J. Kuriansky as the new Deputy Attorney General for Medicaid Fraud Control, succeeding Mr. Hynes, who had resigned to become New York City Fire Commissioner.

The patient abuse program in the Deputy Attorney General's Office focuses directly on the vital issues of patient care and treatment. The principal function of the Unit is to investigate and, when appropriate, to prosecute cases of assault, gross neglect, reckless endangerment and unsafe conditions which threaten the health of patients. In addition, the Unit refers appropriate cases to the Department of Health and the Department of Education for administrative action. Currently, in New York City, two attorneys and six investigators, two of whom are registered nurses, are assigned to the Patient Abuse Unit. In each of the other six regional offices of the Deputy Attorney General, located in Albany, Buffalo, Long Island, Rochester, Syracuse and Westchester-Rockland, at least one attorney and one investigator have primary responsibility for the investigation of allegations of abuse, neglect and mistreatment of patients and residents.

In addition to investigating allegations of abuse of individual patients, the Unit conducts special inquiries into general conditions affecting all patients. Two of these special inquiries concerned summer heat emergencies and resulted in reports recommending reforms in regulating the residential health care system.

Other activities of the Patient Abuse Unit include maintaining active liaison with state agencies and community groups interested in improving conditions in nursing homes, and participating in training ombudsmen and facility employees.

Based upon information obtained during the course of the Office's investigations, the Deputy Attorney General has urged various administrative and legislative changes to improve the delivery of patient care, including reform of nursing home regulations on both the state and federal levels. All of these activities will be more fully described in this report.

INDIVIDUAL INVESTIGATIONS

A review of patient abuse cases investigated from 1975 through 1980 indicates that the Patient Abuse Unit has dealt primarily with allegations within the following categories of abuse:

-- Deaths of patients under suspicious circumstances or circumstances indicating deficient care;

-- Assaults, including sexual abuse;

-- Rough treatment;

-- Unexplained physical injuries;

-- Facility conditions or staff neglect which endanger the health and safety of patients;

-- Deteriorated patient condition attributable to reckless treatment.

The Patient Abuse Unit has received complaints from various sources including victims, friends or relatives of victims, public officials, and facility employees. Since the enactment of the Patient Abuse Reporting Law (Public Health Law §2803-d) in 1977, the majority of cases investigated by the Unit have

been referred by the New York State Department of Health. [See pp. 10-14, infra]. The number of complaints investigated by the Patient Abuse Unit has increased from 143 in 1976 (the first full year of investigations) to over 300 in 1980. Two-thirds of the complaints involved patients in proprietary facilities. One-quarter of the complaints concerned patients in voluntary facilities. The remaining 8% of the cases concerned patients in public homes. [Appendix I, Table 1]

The largest category of complaints investigated by the Patient Abuse Unit concerned allegations of neglect. These allegations, which comprised 26% of the total number of complaints, concerned inadequate medical or custodial care (including inattentiveness, careless medication practices, and failure to treat decubitus ulcers) or other situations creating risks (such as leaving a weak, nonambulatory patient unattended on a toilet, bathing a patient with scalding water, or moving a patient in an unsafe manner).

Assault allegations represented 24% of all complaints investigated. These allegations concerned conduct such as slapping, kicking, pinching or hitting a patient; sexual abuse; or a physical invasion of a patient by a foreign object under the control of a staff person (including cases where feces had been placed in a patient's mouth and where a rubber glove had been tied around a patient's penis).

Eleven percent of complaints investigated involved unexplained physical injuries including bruises, lacerations, fractures, swellings or other similar injuries of unknown cause.

The fourth most prevalent type of complaint, accounting for 9% of the Unit's caseload, was rough treatment. These complaints alleged unnecessarily forceful treatment during the course of care, such as jerking the patient during transfer from wheelchair to bed or physical behavior which did not rise to the level of an assault, such as squirting water on a patient. [Appendix I, Tables 2 and 3]

With the implementation of the Patient Abuse Reporting Law in 1978, the number of complaints and referrals received by the Patient Abuse Unit increased dramatically. The Unit's paramount law enforcement responsibility, together with limited staff resources, necessitated a shift in emphasis in the type of complaints investigated to those cases having a potential for criminal prosecution. Thus, the Unit began referring cases of missing or wandering patients (which comprised 13% of its work in 1977) to the appropriate local police department. Verbal abuse allegations, which were 6% of the 1978 caseload, are currently referred to the Department of Health inasmuch as verbal abuse alone does not constitute a crime under the Penal Law. Similarly, complaints alleging failure to comply with nursing home regulations such as improper placement, poor food, dirty linens, or inadequate familial communication are now, barring exceptional circumstances, referred to the Department of Health. [Appendix I, Tables 2 and 3]

In 37% of all cases investigated, a specific person or target was alleged to have caused an injury or to have jeopardized the health and safety of a patient. The persons most

often accused of this abusive conduct were nurses' aides and orderlies. In complaints of assault where a target was identified, 62% were nurses' aides and 26% were orderlies. In cases of unexplained physical injuries where investigations eventually revealed a target, 79% of the targets were nurses' aides and 16% were orderlies. Where specific persons were alleged to have treated patients roughly, 66% were nurses' aides and 19% were orderlies. [Appendix I, Tables 4-6]

The Patient Abuse Unit closes the vast majority of cases investigated without taking prosecutive action. Investigations often reveal that there is insufficient evidence to meet the legal standard of proving beyond a reasonable doubt that a crime has been committed. In some cases, sufficient evidence cannot be adduced to charge a specific person with a specific crime. In others, the evidence may not spell out an injury as that term is defined by the Penal Law. Even where an abuser has been identified and an injury has been sustained, the criminal intent of the abuser cannot always be conclusively demonstrated.

Through December 1980, the Unit had prosecuted seven cases of assault and one case of endangering the welfare of an incompetent. Three defendants were convicted; three were acquitted after trial; and two cases were dismissed by the court.

Delays in the judicial process were a significant contributing factor in the acquittals and dismissals, as time took a harsh toll on the elderly and sick victim/witnesses in these

prosecutions. In one case, a licensed practical nurse allegedly whipped a seventy-seven year old nursing home resident across the back with a towel. At a lineup held at the nursing home shortly after the incident, the victim identified his assailant. However, when the trial was eventually held almost two years later, the judge dismissed the case because the victim was unable to correctly identify his assailant. The three cases resulting in acquittals involved similar problems. The trials were held approximately a year after the incidents. In each case, the victim was the only witness to the incident and was unable to correctly identify the attacker at trial. In addition, because of the length of time before trial, the quality of the victim's narrative had deteriorated. Details, such as time of day and clothing worn by the assailant, became less certain and the testimony of the victim was easily discredited.

In each of the cases where a conviction was obtained, there were other witnesses, generally facility employees, who observed the incidents. In two cases, the defendants pleaded guilty. In the third case, the trial was held within six months of the assault.

One hundred and fifty-two complaints investigated by the Deputy Attorney General were subsequently referred to other agencies [Appendix I, Table 7]. Administrative violations were referred to the New York State Department of Health for appropriate action. Where unprofessional conduct was suspected, the Deputy Attorney General referred cases to the New York State

Department of Education. Examples of cases referred to the Department of Education include:

-- Two licensed practical nurses were responsible for a patient's care; one during the evening shift, the other during the night shift. Although the patient had a history of heart trouble and had just returned to the home that very day from a hospital following treatment for a heart attack, neither nurse gave ordered medication to the patient because the medication had not been delivered. When the patient complained of chest pains, the night nurse did not contact the physician because she believed that the evening nurse had done so. The patient died at the nursing home the day following her return from the hospital.

-- A registered nurse failed to follow a physician's orders to apply a warm compress to a patient's ecchymotic area. Instead, she applied a "Kwik Heat" pack. She failed to consult the facility's manual which outlined the proper use of "Kwik Heat" and failed to observe the patient for possible adverse reactions. On the following morning the patient was discovered to have second degree burns on the treated area.

-- A licensed practical nurse was responsible for administering medication to forty patients. Between 8:15 a.m. and 8:55 a.m. she gave medication to thirty-four patients. However, she recorded only twenty-eight distributions and failed to administer medications at all to the remaining six patients for whom she was responsible. She allegedly stated that she did not administer the medications because they were "unimportant."

From 1978 through 1980, the Deputy Attorney General referred nine registered nurses and eleven licensed practical nurses to the Department of Education for a review of professional conduct. To date, the Department of Education has taken some disciplinary action in five of these cases and closed eight others without further action. Seven cases remain under active investigation.

The Impact of the Patient Abuse Reporting Statute

The Patient Abuse Reporting Statute (Public Health Law §2803-d) requires that incidents of physical abuse, neglect and mistreatment of patients in New York State long term care facilities be reported to the Department of Health. The law, in effect since September 1977, was designed to reveal instances of patient abuse which might otherwise have gone unreported or undetected. Amendments to the law became effective in September 1980.

There are several explanations for the frequent failure of patients to report abuse. A fundamental reason is the nature of the nursing home patient/employee relationship; namely, the nursing home patient depends totally on staff to respond to his or her basic needs. Patients and their families deeply fear retaliation and may endure abuse rather than risk the consequences, real or imagined, of reporting alleged mistreatment. The physical and mental condition of patients also contributes to the low rate of reporting. Many patients, afflicted with varying degrees of senility, are unaware that they have been abused. In one investigation, for example, an orderly stuck a patient's head with diaper pins. Fortunately, another employee reported the abuse, because the patient had been totally unaware of what had happened to him. Other patients do not report abuse because they are blind or deaf and unable to identify an abuser. In addition, the mechanics of reporting often prove too taxing for the patient. Few patients have telephones

in their rooms; public telephones are located in hallways, affording only minimal privacy. A complaint by letter can be even more difficult for a patient who can no longer write or who fears interception of the letter.

Prior to the enactment of the statute, reporting by facility staff was also infrequent. In the two years and three months preceding the Patient Abuse Reporting Law, employees of nursing home facilities reported twenty-two cases to the Deputy Attorney General. Employee witnesses feared retaliation by accused co-workers. Many also believed that no corrective action would be taken, rendering their efforts futile.

Recognizing these problems, the Legislature imposed a legal duty on certain staff to report cases of suspected abuse. Although the reluctance to report may still exist, staff now face censure, suspension or revocation of their licenses for failure to report. Under the 1980 amendments to the reporting law, a staff member can also be fined up to $1,000 for not reporting.

Under the law passed in 1977, only licensed professionals in skilled nursing and health related facilities were required to report incidents of patient abuse. The 1980 amendments expanded the categories of persons who must report to include all residential health care facility personnel and the facility operator, as well as licensed personnel, whether or not they are employed by the facility. Thus, physicians, registered nurses, licensed practical nurses, certified social workers, administrators, as well as nurses' aides, orderlies,

housekeepers and clerks are now required to report suspected patient abuse.

Public Health Law Section 2803-d requires that a report be made whenever there is "reasonable cause to believe" that physical abuse, neglect or mistreatment has occurred. According to the regulations, "reasonable cause to believe" exists if, upon a review of the surrounding circumstances, a prudent person would form the opinion that an abuse has occurred.

The law presumes the good faith of a person filing a report and thus holds such a person immune from civil or criminal liability. In addition, under the 1980 amendments, a person who makes a complaint in good faith cannot be discharged from employment or otherwise harassed or discriminated against because of the report.

A Memorandum of Understanding provides for referrals by the Department of Health to the Deputy Attorney General's Office of all Section 2803-d complaints. Upon receipt of a complaint, the Department's Patient Advocate must immediately advise the Deputy Attorney General's Office, which in turn accepts all those referrals where it appears that a crime may have been committed.

Each allegation referred to the Deputy Attorney General's Office is also investigated by the Patient Advocate. This practice does not result in duplication of effort, however, because each agency has a distinct function to perform. The Department of Health is a regulatory agency which monitors and

enforces administrative regulations. It may pursue civil remedies against persons or facilities which fail to comply with required standards. However, the Department of Health has no criminal jurisdiction. In contrast, the Deputy Attorney General is charged under Executive Law Section 63(3) with the responsibility of investigating and prosecuting crimes committed in skilled nursing and health related facilities. Furthermore, the Deputy Attorney General is also responsible for conducting an overall inquiry under Executive Law Section 63(8) into the health, safety and welfare of patients at these facilities and reporting relevant findings to the Governor.

The Memorandum of Understanding also provides that if a particular complaint suggests the commission of a serious crime such as homicide or rape, the Department of Health will defer its investigation, if requested to do so by the Deputy Attorney General's Office, in order to prevent the inadvertent overlooking or loss of relevant evidence. Understandably, the Patient Advocate's health care professional may not necessarily be familiar with the type of, or proper method of obtaining, evidence essential to an effective criminal prosecution.

The increase in the number of cases reported since the advent of the Patient Abuse Reporting Law demonstrates the significance of the statute. In the two years and three months prior to its implementation, the Deputy Attorney General's Office investigated 293 complaints of patient abuse. Of those complaints, 126 were received from family and friends of patients, and ten were from the victims themselves. Facility

staff reported only twenty-two complaints. The remainder of the complaints were received from public officials, the Department of Health, the media and community groups. When the Memorandum of Understanding became operational in April 1978, the number of complaints rose sharply and the source of these complaints changed dramatically. [Appendix I, Tables 8 and 9] From April 1978 through December 1980, this Office investigated 811 complaints. The number of cases reported directly by friends and relatives fell off significantly while the Department of Health became the single greatest source of patient care complaints.

Public Health Law Section 2803-d has unquestionably helped expose incidents of abuse in skilled nursing and health related facilities. Reporting has increased substantially since its enactment. The network of those who report cases has expanded to include those who work with the institutionalized elderly on a daily basis. Moreover, the law has heightened the awareness of staff to the problem of abuse and increased their sensitivity to the needs of the elderly infirm. This has been accomplished through their participation in the investigation process and the training given to staff concerning the new law. Perhaps most importantly, these patient abuse investigations have permitted further identification and understanding of some of the causative factors and problems underlying nursing home abuse.

SPECIAL PROJECTS

Queens County Grand Jury Report

In June 1979, a Queens County Grand Jury, empaneled at the request of the Deputy Attorney General, reported on its exhaustive inquiry into the deaths of two patients and the emergency hospitalization of seventeen other patients of a Queens County nursing home during the heat wave of July 18-23, 1978.

According to the Grand Jury, patients of the facility were exposed to temperatures inside the building approaching 100° due to a breakdown of the air conditioning system, and the home's administrative, nursing and medical staff took no meaningful affirmative measures to protect patients from the dangers attributable to such extreme heat. The report cited the absence of trained staff, inadequate emergency guidelines, a failure of leadership and, in some instances, an inexplicable insensitivity to human suffering.

The Grand Jury recommended actions to prevent the occurrence of similar incidents in the future. It proposed that

additional staff be provided to assist in a heat emergency and that all staff be trained in heat emergency procedures. The Grand Jury urged that staff be required to sponge bathe patients, to force fluids, to remove unnecessary patient clothing and bedding, to ascertain potentially contraindicated medications, and to obtain new orders from attending physicians. It also advocated requiring notification of any such heat emergency to the Department of Health, attending physicians, affiliated hospitals, local emergency service agencies and next of kin.

The Grand Jury further recommended that the State Hospital Code be amended to require each facility to maintain either (1) a functioning backup, emergency air conditioning and heating system, or (2) a current written service contract for the repair and maintenance of the facility's air conditioning and heating systems.

In addition, the Grand Jury recommended the training and licensing of nurses' aides and orderlies, who were found to provide the most frequent "hands-on" care to the elderly patients.

Commenting on the Grand Jury's report shortly after its issuance, the Regional Director, Bureau of Health Standards and Quality, U.S. Department of Health, Education and Welfare, stated: "[T]he report has enormous professional and ethical implications for all, including regulatory agencies, who have responsibility for the health and safety of the extremely vulnerable and dependent patient population residing in long

term care facilities." He urged all administrators of long term care facilities to obtain the report, which he labeled "required reading for all key staff, including physicians," and to evaluate their facilities' capability for coping with such heat emergencies in light of the report's recommendations.

Workmen's Circle Report

A second report concerning the care, treatment and safety of patients during a heat wave was issued by the Deputy Attorney General in September 1980 pursuant to Executive Law Section 63(8). An in-depth study of the deaths of fifteen patients of the Workmen's Circle Home and Infirmary for the Aged in the Bronx concluded that there was insufficient evidence to prove criminal conduct during the heat wave of July 1980, but cited staff behavior which complicated patients' care and jeopardized their safety. In addition, the report noted that none of the recommendations made by the Queens County Grand Jury in June 1979 had yet been adopted by the State Hospital Review and Planning Council, the body within the Department of Health with authority to promulgate regulations governing residential health care facilities.

The Workmen's Circle Report reiterated many of the recommendations of the Queens County Grand Jury and urged reforms designed to prevent potential health disasters during future heat waves. The report recommended that a heat emergency should be specifically defined by temperature; that in the event of such a heat emergency, facility staff should be

required to notify the Department of Health, neighboring hospitals, attending physicians and patients' families; and that there should be adequate staff trained in implementing heat emergency health measures. The report set forth guidelines for ensuring proper temperature inside facilities. It proposed the formation of a Heat Emergency Task Force to monitor, inspect and certify compliance with existing guidelines and to require the transfer of patients to cooler facilities if necessary. The report also recommended an increase in basic diagnostic equipment necessary for performing routine chemistries, urinalyses and blood counts at all nursing homes.

It should be noted that the Department of Health issued a memorandum to all facilities on June 18, 1981 which reviewed state requirements and "generally accepted patient care practices" during a heat wave. It recommended many of the precautions and procedures outlined in the 1979 Queens County Grand Jury and 1980 Workmen's Circle Reports. However, these recommendations do not have the same force or effect, nor would they ensure the same degree of compliance, as would departmental regulations. Moreover, absent specific and binding regulations, it would be extremely difficult to sanction those facilities which fail to implement the recommendations contained in the memorandum. The heat disasters of 1978 and 1980 establish the need for specific, enforceable heat emergency regulations. The Deputy Attorney General urges that they be

promulgated before another long hot summer - with its potential for human tragedy - is once again upon us.

Inspection Program

Prior to September 1981, the Department of Health was required to conduct two inspections of every nursing home in the state each year, at least one of which had to be unannounced. Between 1975 and 1980, staff of the Deputy Attorney General's Office joined the Department in twenty-three rounds of unannounced inspections. Attempts were made to visit at least seven nursing homes throughout the state in each round, but a home's administration sometimes exercised its right to refuse to admit a team from the Deputy Attorney General's Office. When admitted, a team consisting of one attorney and one investigator accompanied the Department's surveyors to ensure that the homes were safe and clean, and that patients and residents were receiving appropriate care. The team focused on fire safety, food service, night coverage, medication practices, and staffing. Such unannounced inspections afforded a meaningful opportunity to make direct observations of conditions of patients and overall cleanliness, served a substantial deterrent purpose, and underscored this Office's continuing concern for patient care.

The benefits of the unannounced inspection process have been somewhat negated, however, by virtue of the fact that these yearly surveys are conducted at approximately the same time each year and therefore are not altogether unexpected by

the facilities. Thus, the predictability of these technically unannounced inspections limits their effectiveness in determining whether facilities are in compliance with state and federal regulations throughout the entire year.

In September 1981, the Legislature reduced the number of required inspections by the Department of Health from two to one per year. This change was necessitated by a reduction in federal reimbursement available for state inspection programs. The new statute does mandate, however, that the remaining inspection be unannounced, comprehensive and, if necessary, followed-up by further inspections to ensure compliance with applicable standards. In addition to this legislative change, the Department of Health, late in 1981, instituted a new survey program under which facilities review their own documents and procedures, and certify required information on report forms provided by the Department of Health prior to an on-site visit. This practice of requiring completion of the survey forms in advance alerts a facility that an inspection will soon be conducted. Thus, the new survey process continues to defeat one of the primary purposes of conducting unannounced, and presumably unpredictable, inspections, and runs contrary to another of the Queens County Grand Jury's recommendations, namely, that the "Department shall take all necessary precautions to insure the confidentiality of the inspection schedule."

Educational, Training and Community Liaison Programs

Members of the Patient Abuse Unit have participated in training sessions for various ombudsman programs. The New York State Office for the Aging conducts an intensive initial training session in order to provide ombudsman volunteers with the information and skills needed to carry out their functions. These sessions have been phased in throughout the state. As new volunteers are recruited, the training is repeated. Attorneys from the Deputy Attorney General's Office have taken part in training sessions conducted in New York City, Syracuse, Rochester, Kingston, Albany, Purchase, White Plains, Utica and Hauppauge. The attorneys discuss the types of complaints within the jurisdiction of the Deputy Attorney General's Office, how an investigation is conducted, and ways in which the ombudsmen and Patient Abuse Unit can work together to achieve their common objective of improved patient care in nursing homes.

In addition to working with the ombudsman programs, the Patient Abuse Unit has maintained active liaison during the past five years with numerous community groups committed to bettering the quality of long term care. Because members of these community organizations actually visit the facilities and patients on a regular basis, they have a unique view of daily conditions and problems. This perspective enables them to act as effective, indeed indispensable, advocates for patients' concerns, including those beyond the scope of criminal statutes and administrative regulation. The Deputy Attorney General

considers the input and contribution of these organizations invaluable in the struggle for quality care for our elderly citizens.

Attorneys from the Patient Abuse Unit have also addressed meetings of the American Arbitration Association and the New York City Chapter of the National Association of Social Workers. Training sessions have been conducted for representatives of the Patient Advocate's Office of the Department of Health and, perhaps most encouragingly, for employees of several New York City nursing homes.

In addition to the educational and training activities within New York State, the Patient Abuse Unit has been consulted by many other states engaged in the drafting of patient abuse reporting legislation as well as the creation and organization of patient abuse investigative units. The Deputy Attorney General's Office has also been invited to address two National Medicaid Fraud Control Unit training conferences, and has exchanged information with representatives of over twenty states regarding patient abuse investigatory tactics and techniques. Although the states vary widely in their approaches to ensuring proper patient care, these exchanges have proven to be a source of new insights into methods of eliminating abuse of the elderly infirm.

State Regulations

Because the quality of care provided to patients in long term care facilities is to a great degree determined by

standards set by state law and regulations, the Deputy Attorney General has consistently sought improvements in these laws and regulations in order to ensure the highest quality care.

The New York State Department of Health monitors residential health care facilities based on regulations promulgated by the State Hospital Review and Planning Council. Currently, two sets of regulations, or codes, are mandated by Public Health Law Section 2803(2)(c). The particular code followed is at the option of the facility. One set of regulations, known as the "Mini Code" (10 NYCRR §400 et seq.), contains the minimum standards necessary to qualify for federal reimbursement under the Medicare and Medicaid programs. The other set of regulations, known as the "Maxi Code" (10 NYCRR §700 et seq.), contains higher standards. As the system was originally conceived, a facility that adhered to the standards of the "Maxi Code" would receive a higher Medicaid reimbursement rate. However, since 1977, when there was an alteration in the state reimbursement formula, there has been no financial incentive to comply with the "Maxi Code" inasmuch as nursing homes receive the same reimbursement regardless of which code they follow. Thus, the only code that has been enforced since 1977 has been the "Mini Code."

In any event, both codes are markedly deficient in defining standards of adequate care and protection of patients of residential health care facilities, and many of the regulations in both codes are virtually unenforceable. The language is often vague and thus subject to varying interpretation. Words such

as "satisfactory," "sufficient," "appropriate" and "adequate" abound. For example, both Section 416.1(f)(1) and Section 731.1(f)(1) state that "the medical staff of a public or voluntary nursing home shall be sufficient to meet the needs of the patients" (emphasis added). Section 416.8(a) states "[t]he operator shall have satisfactory arrangements for: (1) identifying the patients' personal and social problems and needs which interfere with the use of medical care services or with recovery or rehabilitation" (emphasis added). In both codes, most regulations are prefaced with the words "the operator shall." Although the operator has the ultimate responsibility for compliance, the codes rarely require him to delegate these responsibilities to specific staff persons who can then be held accountable for failure to comply.

In 1977, a new code, known as the "New 700," was drafted by the Department of Health with input supplied by operators, consumer groups, the Deputy Attorney General and other governmental agencies. The new code revisions focus on four areas: patients' rights; medical services and the use of restraints; staffing; and enforcement and accountability.

In the area of patients' rights, the New 700 requires that facilities establish and publicize in-house grievance procedures and inform patients of complaint mechanisms. The Code protects and extends visitation rights. It prohibits discrimination in admission or retention of patients on the

bases of age, handicap, or source of payment.[1]

The New 700 requires that patients and their families be informed of the name, address and telephone number of attending physicians. It also establishes procedures for the use of both physical and chemical restraints, and specifically addresses such concerns as proper length and frequency of use.

The new code requires additional staffing for nursing, social work and leisure time activities. It extends the requirements of licensed nursing coverage in health related facilities from day shifts to all shifts, every day. It requires one full-time social worker for every 100 beds available for patients and an activities program seven days a week at all facilities.

The New 700 contains specific, enforceable language and ensures that administrators and other employees are accountable for compliance.

For over three years a coalition known as the Ad Hoc Coalition for a Single Standard Code has sought implementation of the New 700. This Coalition is comprised of over forty agencies and organizations throughout the state, including consumer

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1 On December 2, 1981, a New York County Grand Jury, empaneled at the request of the Deputy Attorney General, issued a report concerning the admission practices of certain voluntary nursing homes in New York State. The report revealed a pattern of solicitation of charitable contributions from prospective patients--many eligible for Medicaid--and their relatives at the time of their application for admission, and recommended certain legislative and administrative measures to curb this abuse.

groups, a professional association, a labor union, and public officials [Appendix II]. The Deputy Attorney General has served as an active consultant to the Coalition.

The Coalition has urged the Department of Health to implement the New 700. The Department has thus far declined to do so citing insufficient funds to reimburse facilities for Medicaid expenditures which would be incurred in meeting the new standards. The Coalition, with the support of the Deputy Attorney General, has therefore requested--unsuccessfully to date--that the Department implement at least those regulations in the New 700 which would not require additional reimbursement.

In addition, the Coalition has sought legislation amending the Public Health Law to require a higher quality single standard code. In 1980, the State Senate passed a bill which would have required a single standard code. However, a similar bill died in committee in the State Assembly because it failed to make clear that the future single standard code would be one which would actually improve the quality of care for residents and contained no guarantee that adequate funds would be available to pay the price for a higher quality code.

In 1981, Assembly Bill No. 8017 was introduced. This bill would mandate a single standard code for all residential health care facilities which is no less stringent than the current "Maxi Code," thus ensuring that whatever code is promulgated will contain higher standards than the currently operative "Mini Code." The Deputy Attorney General, writing in support of this proposal, observed that this "single Code would both

facilitate compliance by the subject facilities and enhance the enforcement capability of the Office of Health Systems Management. Moreover, the institutionalized elderly in New York State surely deserve the protection and improved standard of care mandated by this bill."

This bill is still pending in the Legislature.

Federal Regulations

Federal regulations, known as Conditions of Participation, establish the minimum standards that states must adopt and that residential health care facilities must meet in order to be eligible for federal reimbursement under the Medicare and Medicaid programs. In New York these standards are currently contained in the "Mini Code" (10 NYCRR §400 et seq.), and they serve as a basis for federal and state agency survey and certification compliance review.

In 1980, the United States Department of Health and Human Services proposed a general revision of the Conditions of Participation. The drafters of the proposed regulations stated that their goals were to simplify and clarify the regulations, to focus on patient care, to promote cost containment while maintaining quality care, and to achieve more effective compliance. The proposed regulations offered notable improvements to the existing code and represented a necessary and promising step toward ensuring proper patient care. The Deputy Attorney General submitted detailed written comments regarding many of the proposals. In addition, a Patient Abuse Unit attorney

testified before a hearing of the Health Care Financing Administration, the division of the Department of Health and Human Services responsible for setting nursing home standards, and highlighted five areas warranting special attention:

First, the Deputy Attorney General strongly approved of the Condition making participation in the Medicare and Medicaid programs by residential health care facilities dependent upon the preservation of patients' rights. In so doing, the proposed regulations strengthened the enforcement mechanism for securing these rights, making them a verifiable part of the survey process.

Second, the Deputy Attorney General addressed the need for air conditioning in residential health care facilities. While the proposed Conditions of Participation require moderate temperatures to be maintained, this simply cannot be accomplished without the use of air conditioning from time to time. The cost of failing to maintain proper temperature is too great in human terms to justify the financial savings of not having air conditioning for patients, many of whom never go out-of-doors. The Deputy Attorney General recommended a phase-in period to minimize the financial burden on the Medicare and Medicaid programs. In addition to this recommendation, the Deputy Attorney General advocated mandating specific steps to be taken in the event of a heat emergency, as previously recommended in the Queens County Grand Jury and Workmen's Circle Reports.

Third, the Deputy Attorney General proposed that facilities be required to hire certified nurses' aides and orderlies as a Condition of Participation.

Fourth, the Deputy Attorney General recommended stringent restrictions on the use of patient restraints.

Finally, the Deputy Attorney General criticized the absence of any standards for terminating a provider from the Medicare and Medicaid programs. Presumably, not every violation of the Conditions of Participation is of sufficient gravity to warrant termination. However, the proposals left unclear which violations of the Conditions would lead to termination and which might be considered appropriate for less drastic remedial measures, thus raising the possibility of arbitrary application of these sanctions.

On January 19, 1981, the proposed federal changes were approved by the outgoing Secretary of Health and Human Services. On January 21, 1981, however, this approval was withdrawn pursuant to President Reagan's order mandating review of all federal regulations. The Health Care Financing Administration is currently conducting a review of all nursing home regulations with a view to reducing costs. As of December 1981, the Administration had not yet formally published its recommendations for regulatory change. It should be emphasized, however, that while cost containment and elimination of unnecessary regulations are unquestionably laudable goals, the findings of the Deputy Attorney General's patient abuse investigation over the past five years demonstrate unequivocally the

critical importance not only of preserving, but of strengthening, those regulations that directly impact on patient care and patients' rights. Any reduction of federal standards (and, particularly, of federal reimbursement) in these essential areas would only serve as a dangerously tempting precedent for financially strapped state governments and as an ominous signal to our vulnerable elderly of a possible return to the scandal-scarred, unenlightened days of the recent past.

PROPOSALS

Amendments to Public Health and Penal Laws

A. Obstacles to Prosecuting Patient Abuse Under Existing Statutes

The Patient Abuse Reporting Statute (Public Health Law §2803-d) was enacted to ensure that instances of patient abuse would be reported. Three years' experience with the law demonstrates that in fact there is a serious problem of nursing home patient abuse.[2] The Reporting Statute was a necessary first step. However, the inherent difficulties in prosecuting abuse cases vividly illustrate the need for criminal statutes aimed specifically at the abuse and mistreatment of the elderly and infirm.

The problems are illustrated in the following composite narrative which typifies cases that the Deputy Attorney General's Patient Abuse Unit has investigated:

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2 In 1980, the Department of Health sustained 45% of its 1,536 cases. New York State Department of Health, Fourth Annual Report to the Governor and the Legislature, Public Health Law §2803-d, March 15, 1981, p. 10.

> Mrs. Jones, an eighty-five year old wheelchair bound patient at the Rest Well Nursing Home, complained to a registered nurse (RN) at 9:00 a.m. that she was hit while getting dressed. Mrs. Jones believed that a nurses' aide hit her but was unsure if it was Mrs. Green or Mrs. Brown. She said that her roommate, Mrs. Smith, had seen the incident but that Mrs. Smith did not want to talk about it. Both Mrs. Green and Mrs. Brown denied that they hit the patient. Upon examination, the RN discovered no lacerations but did observe a reddened area with a slight swelling on the patient's right leg, just below the knee. Mrs. Jones complained that her leg hurt, but no pain medication was prescribed. X-rays revealed no internal injuries. Mrs. Jones's son urged his mother not to cooperate with the investigation.

Patients like Mrs. Jones are often no longer mentally alert and thus cannot meaningfully assist in an investigation. Such patients and their families frequently fear retaliation by staff members and often refuse to cooperate. Generally there are no other witnesses to an alleged incident. It is also emotionally upsetting for elderly and sick victims to talk about such matters. Finally, even if it can be documented that an incident has occurred and even if the victim is willing and able to testify and a suspect has been properly identified, the facts of a typical patient abuse case often do not fit within the narrow provisions of the existing New York State Penal Law.

The Penal Law requires that there be a physical injury in order to prosecute an assault. A physical injury is defined as an "impairment of physical condition or substantial pain" (Penal Law §10.00(9)). Under current judicial interpretation, a court might well not consider Mrs. Jones's injury to be an impairment of physical condition or substantial pain. This view is based on a 1980 New York State Court of Appeals

decision. While recognizing that pain is subjective, the Court of Appeals held in the case of Matter of Philip A., 49 N.Y.2d 198 (1980), that there is an objective level below which there can be no physical injury as a matter of law. The Court stated that "petty slaps, shoves, kicks, and the like, out of hostility, meanness, and similar motives" are not within the definition of a physical injury.

Lower court cases decided after Philip A. suggest that additional information about the circumstances surrounding the incident and the injury (particularly the victim's own perception of the injury) may permit such cases to go to a jury.[3] However, these decisions indicate that the victim must be able to effectively express the extent of the pain or impairment. To these courts, "substantial pain" has become articulated pain. In many of the cases that the Patient Abuse Unit has investigated, the elderly victims were, not surprisingly, unable or unwilling to express themselves.

The abuse most often reported to the Deputy Attorney General's Office technically falls within the Penal Law definition of harassment.

> A person is guilty of harassment, when, with intent to harass, annoy or alarm another person:
>
> 1) He strikes, shoves, kicks or otherwise subjects him to physical contact, or attempts or threatens to do the same; . . .[4]

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3 See People v. Almonte, N.Y.L.J., February 25, 1980, p. 15, col. 2 (Sup.Ct., N.Y.Co.); People v. Moore, N.Y.L.J., April 14, 1980, p. 12, col. 5 (Sup.Ct., Queens Co.); People v. Gordon, N.Y.L.J., March 13, 1981, p. 5, col. 1 (App. Term 1st Dept.), leave to appeal denied, 53 N.Y.2d 842 (1981).

4 Penal Law §240.25.

Unlike assault, physical injury is not an element of harassment. However, harassment is not a crime, but merely a violation. The possible sanctions imposed for conviction of a violation range only from unconditional discharge to a maximum of fifteen days in jail. Moreover, an harassment conviction does not even result in a criminal record and is thus altogether unavailing as a means of tracking convicted patient abusers. Therefore, for most patients, the significant physical and emotional disruption associated with leaving a nursing home to appear in court militates against prosecuting such a minor harassment charge.

Cases involving neglect of patients rather than affirmative acts of physical abuse are also difficult to prosecute. Statutes which generally apply to neglect situations, such as endangering the welfare of an incompetent, reckless endangerment, and criminally negligent homicide, are seldom applicable in patient abuse matters. To date, the Deputy Attorney General's Office has been able to prosecute only one case of endangering the welfare of an incompetent person. This is due to the fact that the majority of patients in nursing homes, although physically frail and infirm, are not necessarily incompetent by reason of "mental disease or defect" as specified in the statute, and thus they are not protected by it.

Reckless endangerment is applicable to reckless conduct which creates a substantial risk of physical injury or a grave risk of death. To constitute recklessness, the actor must be

aware of and consciously disregard such risk and the conduct must be a gross deviation from the standard of care that a reasonable person would observe in the situation. Moreover, if the conduct involves an omission or failure to act (as is often the case in neglect situations), rather than an affirmative reckless act, a person may not be found guilty of reckless endangerment unless the law imposes a duty on him to perform the act which he failed to perform. Since current laws and regulations rarely assign responsibility to specific staff members, the elements of the crime of reckless endangerment can seldom be made out.

The crime of criminally negligent homicide presents equally insurmountable difficulties in prosecuting patient abuse matters. To prove this particular crime, the People must establish beyond a reasonable doubt that the defendant's criminally negligent conduct caused the victim's death. In cases involving sick and often debilitated elderly persons, it is usually impossible to establish conclusively that death was caused by negligence rather than by some other, natural cause. Even if causation can be proved, the People must also show that the defendant failed to perceive a substantial and unjustifiable risk that death would occur and that the failure to perceive it constituted a gross deviation from the standard of care that a reasonable person would observe in the situation. As with reckless endangerment, the evidence rarely satisfies this standard. In fact, the Deputy Attorney General's Office has never been able to bring a case of criminally negligent homicide.

As the foregoing review of current statutory provisions reveals, the New York State criminal law is simply inadequate in addressing the unique problem of abuse of nursing home patients.

B. Legislation Enacted in Other States

A number of our sister states have already devised criminal statutes to deal with the specialized problems of prosecuting patient abuse cases.

The Arkansas Legislature enacted a penal statute in 1977 governing "adult abuse."[5] The Legislature stated its intent as follows:

> The General Assembly recognizes that rehabilitative and ameliorative services are needed to provide for the detection and correction of the abuse, maltreatment, or exploitation of adults who are unable to protect themselves. Such abuse, maltreatment, or exploitation includes any willful or negligent acts which result in neglect, malnutrition, sexual abuse, unreasonable physical injury, material endangerment to mental health, unjust or improper use of an adult for one's own advantage, and failure to provide necessary treatment, attention, sustenance, clothing, shelter, or medical services.[6]

The statute provides for three gradations of the crime of abusing an adult. The most serious offense provides that "whoever, willfully or by culpable negligence, deprives an adult of, or allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable

5 Ark. Stat. Ann. §59-1301 et seq.

6 Ark. Stat. Ann. §59-1302.

negligence permits the physical or mental health of the adult to be materially endangered, and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to such adult," shall be guilty of a felony.[7] The two other gradations of abuse constitute misdemeanors.[8]

The Arkansas provisions apply to "developmentally disabled adults"[9] and to those adults suffering from the "infirmities of aging."[10] Abuse and maltreatment are defined under the statute to include conduct resulting in malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidental means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing,

7 Ark. Stat. Ann. §59-1303(1).

8 "Whoever willfully or by culpable neglect, deprives an adult of, or who allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable negligence permits the physical or mental health of an adult to be materially endangered, shall be guilty of a Class B misdemeanor. . . ." Ark. Stat. Ann. §59-1303(2).

"Whoever negligently deprives an adult, or allows an adult to be deprived of, necessary food or shelter or medical treatment, is guilty of a Class C misdemeanor. . . ." Ark. Stat. Ann. §59-1303(3).

9 "Developmentally disabled adult" is defined as "an adult having a disability attributable to mental retardation, cerebral palsy, epilepsy, or other neurological condition related to mental retardation or requiring treatment similar to that required for mentally retarded individuals, which has continued or can be expected to continue indefinitely, and substantially prevents the individual from adequately providing for his own care and protection." Ark. Stat. Ann. §59-1301(1).

10 "Infirmities of aging" is defined as "chronic brain damage caused by advancing age or other physical deterioration to the extent that the person is substantially impaired in his ability to adequately provide for his own care and protection." Ark. Stat. Ann. §59-1301(2).

shelter, supervision or medical services.[11]

South Carolina has also enacted a statute to prohibit the abuse, neglect and exploitation of certain classes of dependent persons:

> It shall be unlawful for any person to abuse, neglect or exploit any senile, mentally ill, developmentally disabled or mentally retarded person or any person who is incapable of caring for or managing his own affairs. This shall not apply to altercations or acts of assault between persons protected by this section.[12]

There have already been several convictions for abuse and neglect of patients in nursing homes under this two-year-old statute, which provides penalties of up to $5,000 and five years in prison.

The Minnesota Legislature has adopted a similar statute directed specifically at patient and resident mistreatment:

> Whoever, being in charge of or employed in any facility required to be licensed under the provisions of sections 144.50 to 144.58, or section 144A.02, intentionally abuses, ill-treats, or culpably neglects any patient or resident therein to his physical detriment may be sentenced to imprisonment for not more than one year or to payment of a fine of not more than $1,000, or both.[13]

To date, there have been two convictions under this statute: one involving employees of a hospital for severely retarded adults, and the other involving an orderly at a nursing home. In both instances, the Attorney General encountered the traditional difficulties associated with prosecuting patient abuse cases. The actual victims of abuse could not testify because

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11 Ark. Stat. Ann. §59-1301(4).

12 S.C. Code §43-29-40.

13 Minn. Stat. §609.231.

of advanced senility. The events in issue were dated because employees who had seen the acts of abuse had been initially reluctant to come forward. In addition, although the accused employees admitted having hit and kicked the residents, they claimed that the residents required firm treatment because they had been unruly or difficult. Furthermore, the defendants asserted that they had not been trained to handle residents who became obstreperous and argued that the amount of force used in the situation did not amount to abuse. Moreover, the language of the statute leaves the meaning of the term "abuse" ambiguous, thereby presenting yet another obstacle to the prosecution. Nevertheless, the Attorney General was able to obtain guilty pleas under this statute in each instance.

Arizona has devised a markedly different statutory scheme which attempts to define, objectively and specifically, certain types of prohibited conduct. Although the statute only applies to the abusive treatment of mentally retarded persons, the approach might well be adapted to protect residents of health and adult care facilities as well:

> A. Improper, abusive treatment or neglect of a mentally retarded person is prohibited. For the purposes of this section:
>
> 1. "Abusive treatment" means:
>
> (a) Physical abuse by inflicting pain or injury to a client. This includes hitting, kicking, pinching, slapping, pulling hair or any sexual abuses.
>
> (b) Emotional abuse which includes ridiculing or demeaning a client, making derogatory remarks to a client or cursing directed toward a client.
>
> (c) Programmatic abuse which is the use of an aversive stimuli

technique that has not been approved as a part of such person's individual program plan and which is not contained in the rules and regulations adopted pursuant to sub-section B of §36-561. This includes isolation or restraint of a client.

2. "Neglect" means:
(a) Intentional lack of attention to physical needs of clients such as toileting, bathing, meals and safety.
(b) Intentional failure to report client health problems or changes in health condition to immediate supervisor or nurse.
(c) Sleeping on duty or abandoning work station.
(d) Intentional failure to carry out a prescribed treatment plan for a client.

B. A person who violates any provision of this section is guilty of a class 2 misdemeanor.[14]

In July 1980, the Massachusetts Legislature enacted a patient abuse reporting law similar to the one in effect in New York. However, unlike New York, Massachusetts has taken the necessary next step and also made it a criminal offense to abuse, mistreat or neglect[15] a long term care patient. The

14 Ariz. Rev. Stat. §35-569.

15 Mass. Gen. Laws c.111 §72F defines abuse, mistreatment and neglect as follows:
"Abuse" is defined as "physical contact which harms or is likely to harm the patient or resident."
"Mistreatment" is defined as "use of medications, isolation, or use of physical or chemical restraints which harms or is likely to harm the patient or resident."
"Neglect" is defined as "the failure to provide treatment and services necessary to maintain the health and safety of the patient or resident, provided, however, no person shall be considered to be neglected for the sole reason that he relies or is being furnished treatment in accordance with the tenets and teachings of a well-recognized church or denomination by a duly accredited practitioner thereof."

statute provides:

> Any person who knowingly and wilfully abuses, mistreats, or neglects a patient or resident of a long-term care facility required to be licensed under section seventy-one of chapter one hundred and eleven, shall be punished by imprisonment in a jail or house of correction for not more than two years or by a fine of not more than five thousand dollars, or by both such fine and imprisonment.[16]

In the short time since its enactment the Massachusetts Attorney General has already initiated six prosecutions under this section.

C. Deputy Attorney General's Proposal

Several New York cases investigated by the Patient Abuse Unit might well have been successfully prosecuted if a Massachusetts-type statute, which does not require physical injury or substantial pain as an element of the crime, had been in effect. For example, in 1978 a patient was allegedly punched in the stomach by a nurses' aide. There were no bruises, and the patient refused to talk about the incident. However, a licensed practical nurse (LPN) at the facility had observed the incident, and could have supplied the testimony necessary to prosecute the aide. In another incident, a nurses' aide allegedly hit a patient in the face twice with a towel after observing a bowel movement in the patient's bed. Again, there were no injuries, but the incident was observed by another nurses' aide. In still another case, a ninety-four year old patient was allegedly hit by an aide with a sheet, struck in

16 Mass. Gen. Laws c.265 §38.

the forearm and kicked in the shins. Although the patient sustained a bruise on her left shin and several marks or bruises on her arm, she was incompetent to testify. Once again, however, another aide had witnessed the incident and could have provided the necessary testimony under a statute like Massachusetts's which does not require the victim to articulate substantial pain.

After reviewing the law and the experiences of other states and analyzing the special problems encountered in the cases investigated by the Patient Abuse Unit in recent years, the Deputy Attorney General has drafted two proposed amendments, one to the Public Health Law and one to the Penal Law, which would make certain abusive or neglectful conduct a criminal offense. The suggested amendment to Public Health Law Section 2803-d would, as in Massachusetts, add a criminal penalty to the existing law requiring the reporting of patient abuse. Under this amendment, the Deputy Attorney General proposes that a person who commits an intentional act of patient abuse or mistreatment, including those so defined by the Commissioner,[17] shall be guilty of a misdemeanor. In addition, it

17 10 NYCRR §81.1(a) defines "abuse" as "inappropriate physical contact with a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility, which harms or is likely to harm the patient or resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping, and sexual molestation."

10 NYCRR §81.1(b) defines "mistreatment" as "inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility."

is proposed that Penal Law Section 260.25 (currently, Endangering the Welfare of an Incompetent Person) be amended by enlarging the protected class to include not only incompetent persons but residents of nursing homes and similar facilities as well. Such an amendment would greatly facilitate the prosecution of neglectful conduct directed at those individuals unable to care for themselves.

These amendments are proposed in recognition of the fact that patient abuse is a unique problem which has all too frequently eluded traditional methods of prosecution. Abusive conduct that is ordinarily not criminal must be treated differently when it is visited upon the sick and elderly by the very persons on whom they depend for all or most of their daily needs. Since almost the turn of the century, this state has shown an historic concern for the health and well-being of its helpless citizens. Criminal statutes have long existed to protect the physical, mental and moral welfare of both children and the mentally disabled.[18] It is now time to extend the same solicitude to our elderly infirm who are equally unable to care for themselves and equally vulnerable to abuse.

18 See, for example, Penal Law §§260.10, 260.25

The Deputy Attorney General's Proposed
Criminal Statutes Relating to Patient Abuse

AN ACT to amend the penal law and the public health law in relation to abuse, mistreatment and neglect of patients in long term care facilities

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 260.25 of the penal law is hereby amended to read as follows:

§260.25 Endangering the welfare of an incompetent or infirm person.

A person is guilty of endangering the welfare of an incompetent or infirm person when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself because of mental disease or defect, physical disability, or because his care has been entrusted to a nursing home, health related facility, adult care facility, or a like institution.

Section 2. Subdivision 7 of section 2803-d of the public health law is hereby amended to read as follows:

7. In addition to any other penalties prescribed by law, (i) any person who commits an act of physical abuse, neglect or mistreatment, or who fails to report such an act as provided in this section, shall be deemed to have violated this section and shall be liable for a penalty pursuant to section twelve of this chapter after an opportunity to be heard pursuant to this section; and (ii) any person who intentionally commits an act of physical abuse or mistreatment, including an act so defined by the commissioner, shall be guilty of a misdemeanor.

EXPLANATION-Matter in italics (underscored) is new.

Certification and Training of Nurses' Aides and Orderlies

As much as eighty to ninety percent of the direct hands-on care provided to residents of long term care facilities is given by nurses' aides and orderlies.[19] These noncertified personnel feed, bathe, dress and move patients. As a result, the quality of life in long term care facilities is in large measure determined by the competence and attitudes of the aides and orderlies. Notwithstanding their critical responsibilities, there are currently no meaningful requirements that these employees be trained in basic geriatric care.

The investigations conducted by the Deputy Attorney General indicate that aides and orderlies are involved in most incidents of abuse of patients. Aides or orderlies were accused in 88% of the assault cases, in 85% of the rough treatment cases and in 95% of the unexplained injury cases with identified targets.[20] In addition, aides and orderlies were frequently accused of negligence, many of the complaints alleging that they were unresponsive and inattentive to patients' needs. A common complaint has been inadequate incontinent care resulting in exacerbation of decubitus ulcers.

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19 Subcommittee on Long-Term Care of the Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy; Suppporting Paper No. 4, Nurses in nursing homes: the heavy burden (the reliance on untrained and unlicensed personnel), S. Rep. No. 355, 94th Cong., 1st Sess. 392 (1975).

20 In 77% of assault complaints and in 83% of rough treatment complaints there was an accused abuser. However, in only 13% of the unexplained injury complaints could a specific target be identified. [Appendix I, Table 4]

Caring for the elderly and infirm presents unique problems. The patients in nursing homes may be incontinent, nonambulatory or unable to control the movements of their limbs; some are totally dependent on facility staff for their care. In addition, patients are often senile, depressed and/or hostile. These special patient care difficulties, prevalent in a nursing home setting, strongly suggest the need for training, state certification and ongoing in-service education of aides and orderlies.

New York State should require nurses' aides and orderlies to complete a prescribed course of training in the care of the elderly and infirm. The state should certify those who successfully complete such a program and should mandate that licensed facilities be permitted to hire only these certified employees.

Several states have enacted certification statutes.[21] For example, Kansas currently requires a ninety-hour certification course for nurses' aides [Appendix III]. A follow-up Task Force in that state recommended that this course be completed within one year of initial employment. It also proposed a forty-hour basic skills training program within seven days of employment [see Appendix IV for proposed curriculum], pre-employment training sessions and continuing in-service education.[22]

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21 K.S.A. §39-936; Cal. Health & Safety Code §§1337-1338.3; Mich. Comp. Laws §333.21795; Minn. Stat. §144A.61.

22 Report of the Task Force on Comprehensive Recruitment and Employment Training For Adult Care Home Aides, as directed by the Kansas Senate Concurrent Resolution 1637, December 1980.

Management and labor in the New York nursing home industry have recognized in-service training as a means of improving the quality of job performance. Some in-service training is regularly conducted. However, the regulations of the Department of Health are not specific with respect to either the amount or substance of in-service training.[23] The Department of Health should adopt minimum and explicit standards for in-service training of aides and orderlies.

In many of the cases investigated by the Patient Abuse Unit, abusive aides and orderlies were subsequently suspended by the facilities; in some cases, they were even dismissed. Nevertheless, this Office has documented cases where aides or orderlies who had been dismissed for abusive conduct at one facility were thereafter hired by another home only to have similar patient abuse complaints lodged against them. For example, one orderly suspected of causing bruises to patients at a nursing home in the Albany region had been previously employed at three other homes in the area, one of which dismissed him twice for threats to the nursing staff and for suspected patient abuse. The individual omitted his past employment record on his application to this latest home and, because he had once worked there briefly, he was hired again after only a limited review of his application. Despite the fact that suspicions circulated about his treatment of patients at the home, that the staff thought him verbally abusive and short-tempered, and that the facility confirmed that he had

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23 See, 10 NYCRR §414.15(a).

lied about his previous employment, the individual remained employed. Decertification would not only provide a mechanism for removing aides and orderlies who are unsuited for direct patient care, but would establish a procedure for tracking and preventing the re-employment of such abusive employees at the same or other facilities.

Accordingly, the Deputy Attorney General believes that the adoption of a coordinated and detailed program of training and certification is essential to ensure (1) that nurses' aides and orderlies have sufficient grounding in the basic skills of caring for the ill and aging, and (2) that there is an effective means of removing and tracking those abusive aides and orderlies ill-suited for the delivery of direct patient care.

Suicide

The Patient Abuse Unit investigates all reports of patient suicides. These investigations do not duplicate police efforts, which concentrate primarily on determining the cause of death. Instead, if a death has been ruled a suicide by the medical examiner, the Deputy Attorney General will attempt to determine whether facility staff were aware of the patient's suicidal tendencies, and, if so, what actions were taken to prevent the suicide. In some cases investigated by the Patient Abuse Unit, patients expressed suicidal ideation prior to the actual occurrence. The Deputy Attorney General therefore

recommends a regulation requiring facility staff to promptly report suicidal ideation, gestures and attempts to the administrator of the facility, who, upon receiving such information, should be required to arrange a psychiatric consultation for the distressed patient.

The Deputy Attorney General has also observed that classic indicators have invariably preceded nursing home suicides. These indicators include permanent impairment of physical condition, separation from or loss of a spouse, initial inability to adjust to an unfamiliar setting, and an abrupt disappointment in familial relations. These indicators have often been ignored or disregarded. The Deputy Attorney General believes that facility staff should be trained to recognize these suicidal indicators and be required to carefully monitor residents when such early warning signs are present.

Fire Safety

To date, New York State has been fortunate in not experiencing a major fire disaster, resulting in multiple deaths or injuries, in any of its long term care facilities. However, the deaths by fire of at least four New York City nursing facility residents within the last two years suggest a need for additional fire safety measures.

-- In November 1979, at 12:30 p.m., while apparently trying to light or smoke a cigarette in a bathroom in a Queens nursing home, a patient set his clothes on fire. A secretary at the facility smelled smoke and looked in the direction of the patient's

toilet. The secretary then ran to the bathroom door with a nurses' aide. When the aide pulled open the door, smoke billowed out thereby activating a smoke alarm in the facility. By the time the fire was extinguished the patient had suffered second and third degree burns over 30% of his body. He died as a result of these burns.

-- In January 1980, while attempting to light a cigarette in a bathroom at 11:30 p.m. in a Bronx nursing home, a patient set fire to her nightgown. While making rounds, a nurses' aide smelled something burning but could not determine where the smell was coming from. When the aide approached the patient's room she heard a crackling sound. It was only after the toilet door was opened that a fire alarm was activated. The burns caused the patient's death.

-- In December 1980, a patient at a nursing home in Manhattan was found ablaze in his room. Apparently, he had been smoking. He was taken to the Burn Unit of New York Hospital with third degree burns over 60% of his body. He died at the hospital. In addition, four employees at the facility suffered smoke inhalation when they tried to combat the fire. Two of the employees required treatment at Bellevue Hospital.

-- In January 1981, a Brooklyn health related facility patient was severely burned in his room. He was reported to be a smoker who required supervision. As a result of his burns, he was transferred to Kings County Hospital where he died.

In recent years, the Deputy Attorney General has frequently urged an increase in fire safety protection measures. Letters advocating installation of additional smoke detectors have been sent to nursing home associations and to the New York State Department of Health. In a letter to the Deputy Attorney General's Office in August 1980, the Deputy Director for Health Facilities Standards and Control for the Department of Health responded, "Installation of smoke detectors in all areas may

help in early detection of fire and thereby reduce the extent of injury or perhaps death, but this is not a certainty. . . . We will continue to exercise our surveillance responsibilities to the best of our ability, but we feel that requiring installation of additional smoke detectors would not necessarily be effective and would result in a significant cost."

Smoke detectors may indeed "reduce the extent of injury or perhaps death" of nursing home patients. In New York City, in fact, smoke detectors are presently required in every multiple dwelling apartment, and hotel room,[24] as well as in all patients' rooms in nursing homes built after 1968.[25] Our elderly nursing home residents are certainly entitled to the same degree of protection afforded every tourist vacationing in a Manhattan hotel. Accordingly, the Deputy Attorney General urges that smoke detectors be made mandatory in every patient's room in all New York State residential health care facilities.

In 1981, the New York State Legislature enacted a bill embodying the recommendations of the Special Fire Safety Task Force which was convened by the Governor in the aftermath of recent tragic fires in New York State and elsewhere. The new law requires, among other things, the development of a uniform state fire prevention and building code to take effect on

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24 Admin. Code of the City of N.Y. §C26-1705.0 (1981) (effective Jan. 1, 1982).

25 Id. §C26-1703.1 (1968).

January 1, 1984. It also provides for the establishment of a seventeen-member council to formulate the new uniform code.

The fire-related deaths investigated by this Office,[26] as well as the catastrophic and highly publicized fires which have occurred with alarming regularity in nursing homes throughout the country in recent months, graphically illustrate the need for strict fire protection measures for residential health care facilities. The sick and elderly of New York State who live in nursing homes, their families, and the employees of these facilities deserve the mental comfort and physical protection that additional fire safety measures would bring. New York should lead the way, as it so often has in health care matters, in addressing this vital area of concern to our elderly institutionalized citizens. Accordingly, the Deputy Attorney General urges the council to give particular consideration to the special hazards confronting infirm and often nonambulatory patients when formulating statewide fire safety standards applicable to nursing homes.

Restraints

The Patient Abuse Unit has investigated twenty-eight cases involving the misuse of restraints in residential health care facilities. Descriptions of two such cases which resulted in patients' deaths follow:

-- In April 1979, a female patient in a Rensselaer nursing home was restrained in a wheelchair with a posey vest. She died of strangulation when she slid down in the chair to a point where her neck was caught on the vest.

-- In August 1979, a female patient in a Schenectady facility had a bedsheet tied around her waist. Left unattended in a wheelchair, she slid down in the chair and the sheet caught her throat. She was unable to call for assistance, and when finally discovered in this position, she was comatose. She died fifteen days later.

Following these deaths the Deputy Attorney General wrote to the Department of Health to urge that the use of bedsheets be prohibited as restraints for patients sitting in chairs, and further recommended that multiple restraints should be used where chest or waist restraints are ordered for seated patients. The latter would require application of a second strap passing between the patients' legs and secured to the seat of the chair. Current regulations concerning restraints are unduly vague, and do not include essential patient protections.[27]

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26 New York City Fire Department statistics indicate that in 1980 alone there were 521 hospital and nursing home fires in New York City resulting in 6 deaths.

27 10 NYCRR §416.11 provides:

Patient restraint. The operator shall establish written policies and procedures acceptable to the commissioner, for the use of restraints to prevent injury to the patient or others, which shall, as a minimum:

(a) Prohibit the use of locked restraints.

(b) Require that a device used to restrain a patient shall be utilized only when authorized in writing by a physician for a specified and limited period of time, except when necessitated by an emergency, approved by the medical director, director of nursing service or in the absence of such individual, a designated licensed nurse or administrator and applied by a licensed nurse who shall set forth, in writing, as a part of the patient record, the circumstances requiring the use of such emergency restraint.

(c) Require that, in addition to the requirements of section 416.10 of this Part, there be consultation with the physician within 24 hours of the emergency administration of a chemical restraint and that such restraint be administered by a licensed nurse.

The Department of Health circulated proposals governing the use of restraints in residential health care facilities in July 1980. On August 1, 1980, the Deputy Attorney General recommended the following amendments to the restraints proposals: (1) that a physician's written order for restraints specify not only the length of time but also the frequency and time of day that the restraints are to be applied; (2) that restraint orders be reviewed monthly rather than annually; (3) that the proposals require a change of position, motion or exercise when restraints are applied; (4) that restrained patients be monitored on a regular and scheduled basis; and (5) that restraints not be used as a substitute for patient care, as punishment, or for the mere convenience of the staff.

The Department of Health's proposed revisions have not to date been formally adopted. Therefore, the Deputy Attorney General urges that new regulations governing the use of restraints and incorporating the aforementioned protections be promptly promulgated.

Guardrails

The Deputy Attorney General has investigated 137 cases of unexplained bruises found on patients. Most of these bruises have appeared on the patients' extremities and were discovered when the patients were in bed. Facility staff members generally discount assault as a cause of these injuries. Instead, the most frequent explanation given for such bruises is self-infliction. Aides report histories of patients flailing

about; medical personnel note fragile skin susceptible to easy bruising.

Most of the bruised patients sleep in beds with metal guardrails which frequently lack any protective padding. The Deputy Attorney General recommends that a regulation be promulgated making specific personnel responsible for padding beds of patients who are known to flail their arms and legs against guardrails and thereby cause injury to themselves.

Medical Care

The Deputy Attorney General has also had occasion to inquire into and report on the quality of care provided by physicians at residential health care facilities. For example, the Workmen's Circle Report observed:

> During the heat wave medical practice at the facility was, at times, confused and erratic. One physician, who had practiced medicine for 30 years, was on duty on July 20th from 8:00 a.m. to 4:00 p.m. He stated that the facility was extremely hot and "unbearable." He was "miserable walking in the corridors." This physician did not come to work on July 21st because of predictions that the temperature would be over 100° and he could not tolerate the heat. A second physician who has been attending at the facility for ten years is not licensed to practice medicine in the State of New York. He practices at the facility pursuant to an arrangement whereby the Medical Director of the facility must countersign each of his orders. This physician allegedly told a third physician who was working for the first time at the facility during the night shift of July 21st-July 22nd that only patients with temperatures of 105° should be transferred from the facility to a hospital. 105° is one degree higher than the actual transfer temperature established by the Medical Director in a directive posted at nursing stations. The third physician stated that his tour of duty was "extremely busy." He was unaware that one patient's condition had become critical at

11:00 p.m. on July 21st. He pronounced the patient dead at 2:50 a.m. on July 22nd. When asked whether the heat had any effect on the patient's demise, the physician responded that he did not know; his field was obstetrics and gynecology.

The Deputy Attorney General has investigated other cases where the quality of emergency medical care, while not criminal, was subject to question. In one case, a patient was discovered unconscious in her bathroom at 6:45 a.m. with a pair of sewing scissors embedded in her throat. The scissors were removed and the patient was revived. The physician who assumed responsibility for the patient's care at 8:00 a.m. did not see her until fifty minutes later. At that time he listened to the patient's lungs for the first and only time. He failed to compare the lung sounds over a period of time to detect possible changes in her condition. At 10:15 a.m. the patient died as a result of an internal hemorrhage. The medical examiner found 1500 cc. of blood in one of her lungs and concluded that the blood had accumulated in the lung because of the wound in her jugular and subclavian veins caused by the scissors.

Other cases investigated by the Deputy Attorney General have reflected delays in transferring patients to hospitals when they have suffered broken bones, renal failure or insulin shock. In such instances, physicians and administrators have generally blamed one another and the Emergency Medical Service.

Furthermore, medical emergencies are not always obvious, and a lack of basic diagnostic equipment in some facilities often forces physicians to make difficult medical choices.

When a physician sends specimens to outside laboratories for analysis, he must either wait the hours or days necessary for the return of a lab report before treating a patient, begin treating the patient prior to receiving the report, or transfer the patient to an acute care facility for more immediate, but perhaps unnecessary and expensive, analysis. Thus, the Deputy Attorney General proposes, as was earlier recommended in the Workmen's Circle Report, that all skilled nursing facilities be required to maintain certain minimal diagnostic equipment on the premises capable of performing routine chemistries, urinalyses and blood counts.

The Unit's investigations of alleged neglect by physicians and nursing staff not only underscore the necessity for improved acute care but strongly indicate the need for better care plans to deal with patients' chronic health problems as well. The Deputy Attorney General therefore enthusiastically supports a report of the New York State Health Planning Commission which urges the State Education Department to review current professional training requirements and make whatever revisions are necessary to assure that adequate emphasis is given, in both curriculum and licensing examinations, to subject areas such as the aging process, the effects of aging, and the problems of the elderly and chronically impaired.[28]

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28 Subcommittee on Staff Resources and Training, Long Term Care Policy Committee, New York State Health Planning Commission, Education and Training of Long Term Caregivers, pp.11, 17, (September 1981).

CONCLUSION

This report has documented the activity and findings of the patient abuse program in the Deputy Attorney General's Office over the past five years. This program, which is unique in character and scope among the thirty state Medicaid Fraud Control Units throughout the country, is designed primarily to investigate and, when appropriate, to prosecute cases of assault, reckless endangerment, gross neglect, and unsafe conditions which threaten the health and well-being of nursing home patients. Moreover, uncovering evidence of patient abuse often complements the Office's other predominant mission, namely, the prosecution of Medicaid fraud and other financial wrongdoing, because poor patient care and deplorable conditions are the not uncommon consequence of operators' greed. Perhaps more importantly, however, nursing home patients and their friends and relatives have frequently reported that the very presence of this highly trained and responsive prosecutorial Unit serves as a source of solace to those elderly New Yorkers it seeks to protect and as a stern deterrent to those who would

abuse them. And finally, the program is deeply committed to discovering, and educating the public about, the underlying causes of patient abuse, and then to proposing appropriate preventive and remedial measures.

The recommendations contained in this report are the result of a thorough review of current laws and regulations and their effect on both prosecuting and preventing nursing home abuse. The proposed amendments to the public health law and penal law recognize the undeniable trauma of abuse and the demonstrated problems inherent in prosecuting crimes committed against the old and infirm. The overwhelming percentage of abuse and neglect cases involving nurses' aides and orderlies strongly indicates the need for stricter training and certification requirements for these employees who deliver the vast majority of direct patient care. The proposed regulations concerning heat emergencies, suicide, fire safety, restraints, guardrails and medical care result directly from a detailed analysis of the findings of actual investigations and the poignant lessons to be learned therefrom.

During the past five years the Deputy Attorney General's Office has examined over 1100 cases of nursing home patient abuse and neglect. With these investigations still continuing at the rate of 300 per year, it is clear that more can yet be done to ensure that the sick and elderly who reside in New York's residential health care facilities remain free from physical, mental and emotional abuse. And, as this report demonstrates, the laws and regulations of this state can, and

should, be strengthened to further guarantee these vulnerable individuals the care, treatment and protection they so richly deserve.

Some years ago, the French writer Simone de Beauvoir was prompted to observe, astutely and not without a certain degree of cynicism: "By the way in which a society behaves toward its old people, it uncovers the naked, and often carefully hidden truths about its real principles and aims." The generosity and swiftness of our response today to the fundamental needs of thousands of our dependent fellow citizens will surely be the measure by which future generations judge us.

APPENDICES & GLOSSARY

Appendix I

Table 1

Distribution of Cases by Type of Ownership

May 1975 - December 1980

	Total	%
Proprietary	780	67%
Voluntary	294	25%
Public	98	8%
Total	1172	100%

Table 2

Types of Complaints Investigated Each Year*

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Assault	12	24	85	82	104	307
Unexplained Injuries	10	11	39	45	32	137
Rough Treatment	5	6	40	35	32	118
Negligence	51	65	67	85	62	330
Verbal Abuse	2	5	20	5	3	35
Isolation or Improper Restraints	4	3	7	8	6	28
Suicide or Patient Death	8	5	11	7	15	46
Unsafe Conditions	3	3	22	2	24	54
Missing or Wandering Patient	12	23	3	0	1	39
Patient to Patient or Visitor to Patient Abuse	3	4	2	9	18	36
Failure to Comply With Regulations	13	19	19	20	9	80
Individual Financial Irregularities	8	3	1	4	2	18
Other	12	13	11	9	7	52
Total	143	184	327	311	315	1280

*Each case could involve more than one type of complaint.

Table 3

Types of Complaints Investigated Each Year By Percentage*

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Assault	8%	13%	26%	26%	33%	24%
Unexplained Injuries	7%	6%	12%	14%	10%	11%
Rough Treatment	3%	3%	12%	11%	10%	9%
Negligence	36%	35%	20%	27%	20%	26%
Verbal Abuse	1%	3%	6%	2%	1%	3%
Isolation or Improper Restraints	3%	2%	2%	3%	2%	2%
Suicide or Patient Death	6%	3%	3%	2%	5%	4%
Unsafe Conditions	2%	2%	7%	0	8%	4%
Missing or Wandering Patient	8%	13%	1%	0	0	3%
Patient to Patient or Visitor to Patient Abuse	2%	2%	0	3%	6%	3%
Failure to Comply With Regulations	9%	10%	6%	6%	3%	6%
Individual Financial Irregularities	6%	2%	0	1%	1%	1%
Other	8%	7%	3%	3%	2%	4%

*Each case could involve more than one type of complaint.

Table 4

Cases In Which a Target Was Identified*

May 1975 - December 1980

	Total Number of Identified Targets	Total Number of Cases	Percentage of Cases in Which a Target Was Identified
Physical Assault	247	320	77%
Unexplained Injuries	19	142	13%
Rough Treatment	99	120	83%
Negligence	71	361	20%
Verbal Abuse	31	38	82%
Isolation or Improper Restraints	8	28	29%
Suicide or Patient Death	1	65	2%
Unsafe Conditions	3	55	5%
Other	49	288	17%
Total	528	1417	37%

*Each case could involve more than one type of complaint.

Table 5

Target of Investigation*

May 1975 - December 1980

	Physical Assault	Unexplained Injuries	Rough Treatment	Negligence	Verbal Abuse
Orderly	63	3	19	4	3
Aide	153	15	65	22	22
Licensed Practical Nurse	24	1	10	12	3
Registered Nurse	7	0	4	10	2
Physician	0	0	1	22	0
Administrator	0	0	0	1	0
Total	247	19	99	71	30

*In cases where a target of investigation was identified.

Table 6

Targeted Personnel By Percentage*

May 1975 - December 1980

	Physical Assault	Unexplained Injuries	Rough Treatment	Negligence	Verbal Abuse
Orderly	26%	16%	19%	6%	10%
Aide	62%	79%	66%	31%	73%
Licensed Practical Nurse	10%	5%	10%	17%	10%
Registered Nurse	3%	0	4%	14%	7%
Physician	0	0	1%	31%	0
Administrator	0	0	0	1%	0

*In cases where a target of the investigation was identified.

Table 7

Disposition by Type of Complaint*

January 1976 - December 1980

	Indictment	Referral to Dept. of Health	Referral to Dept. of Education	Closed Without Referral	Other
Physical Assault	8	21	4	260	9
Unexplained Injuries	0	7	0	131	1
Rough Treatment	0	7	2	105	2
Negligence	0	38	10	306	2
Verbal abuse	0	1	0	32	2
Isolation or Improper Restraints	0	4	0	23	0
Suicide or Patient Death	0	4	0	54	2
Unsafe Conditions	0	5	0	29	19
Other	2	34	9	231	4
Total	10	121	25	1171	41

*Each case could involve more than one type of complaint.

Table 8

Source of Cases Reported Each Year
January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Victim	8	1	3	1	1	14
Friend	7	1	1	2	0	11
Relative	44	65	36	24	18	187
Patient Advocate/ Department Of Health	4	14	171	230	238	657
Staff	9	9	17	7	9	51
Public Official	18	24	7	9	4	62
Anonymous	7	7	5	2	10	31
Other	19	25	30	4	13	91
Total	116	146	270	279	293	1104

Table 9

Source of Cases By Percentage

January 1976 - December 1980

	1976	1977	1978	1979	1980	Total
Victim	7%	1%	1%	0	0	1%
Friend	6%	1%	0	1%	0	1%
Relative	38%	45%	13%	8%	8%	17%
Patient Advocate/ Department of Health	3%	10%	63%	83%	79%	60%
Staff	8%	6%	6%	3%	4%	5%
Public Official	16%	16%	3%	3%	1%	6%
Anonymous	6%	5%	2%	1%	4%	3%
Other	16%	17%	11%	1%	5%	8%

Appendix II

The Ad Hoc Coalition for a Single Standard Nursing Home Code

Member Organizations

The Alliance of Aged & Disabled

American Jewish Congress

Associated Y's of Greater New York

Central Bureau for the Jewish Aged

Citizen Leaders for Action

Coalition of Institutionalized Aged and Disabled

Community Action for Legal Services

Community Advocates

Community Council of Greater New York, New York City Nursing Home Patient Ombudsman Program

District 1199

Friends and Relatives of Institutionalized Aged (FRIA)

Gray Panthers, New York City Chapter

Institute on Law and Rights of Older Adults, Brookdale Center on Aging

Joint Consumer Council, Health Insurance Plan of New York

Junior League of Brooklyn

Legal Services for the Elderly Poor

Monroe County Nursing Home Patient Ombudsman Program

Nassau Action Coalition

National Association of Social Workers, New York City Chapter

National Council of Jewish Women, New York City Section

New York City Coalition for Community Health

New York City Coalition to Improve Nuring Home Care

New York City Foundation for Senior Citizens

New York Joint State Legislative Committee, National Retired Teachers Association/American Association of Retired Persons

New York Society for Ethical Culture

New York State Coalition for Improved Long Term Care (CILT)

New York State Coalition of the Concerned for Older Americans (COCOA)

New York State Conference for the Aging

New York State Nurses Association

New York State Office for the Aging

New York Statewide Senior Action Council

Nursing Home - Long Term Care Committee, United Hospital Fund

Office of Manhattan Borough President Andrew Stein

Relatives Association of the Daughters of Jacob Geriatric Center

Selfhelp Community Services

Senior Citizens Action Council of Monroe County

State Communities Aid Association

West Side Interagency Council on Aging

Women's City Club of New York City

Appendix III

Excerpted from Kansas Statutes Annotated

K.S.A. 39-936. Education and training of unlicensed personnel

A qualified person or persons shall be in attendance at all times upon residents receiving accommodation, board, care, training or treatment in adult care homes. The licensing agency may establish necessary standards and rules and regulations prescribing the number, qualifications, training, standards of conduct and integrity for such qualified person or persons attendant upon the residents. Unlicensed employees of an adult care home who provide direct, individual care to residents under the supervision of qualified personnel and who do not administer medications to residents shall not be required by the licensing agency to complete a course of education or training or to successfully complete an examination as a condition of employment or continued employment by an adult care home during their first ninety (90) days of employment. The licensing agency may require unlicensed employees of an adult care home who provide direct, individual care to residents and who do not administer medications to residents after ninety (90) days of employment to successfully complete an approved course of instruction and an examination relating to resident care and treatment as a condition to continued employment by an adult care home. A course of instruction may be prepared and administered by any adult care home or by any other qualified person. A course of instruction prepared and administered by any adult care home may be conducted on the premises of the adult care home which prepared and which will administer the course of instruction. The licensing agency shall not require unlicensed employees of an adult care home who provide direct, individual care to residents and who do not administer medications to residents to enroll in any particular approved course of instruction as a condition to the taking of an examination, but the licensing agency shall prepare guidelines for the preparation and administration of courses of instruction and shall approve or disapprove courses of instruction. Unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications to residents may enroll in any approved course of instruction and upon completion of the approved course of instruction shall be eligible to take an examination. The examination shall be prescribed by the licensing agency, shall be reasonably related to the duties performed by unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications to residents and shall be the same examination given by the licensing agency to all unlicensed employees of adult care homes who provide direct, individual care to residents and who do not administer medications.

Appendix IV

Recommended Forty-Hour Post-Employment Curriculum Outline*

I. Introduction to Being a Nursing Home Aide (6 hours)

- A. Long Term Care Philosophy
- B. Job Description
  1. Appearance and Conduct (Behavior)
  2. Chain of Command
  3. Personnel Policies
  4. Fire/Accident Prevention and Safety Prevention (Sanitation)
- C. Federal and State Regulations
  1. Licensure
  2. Confidentiality
- D. Legal Aspects
  1. Residents' Rights
- E. Normal Aging Process

II. Physical Needs of the Resident (14 hours)

- A. Hygiene
  1. Bathing (bed, tub, shower)
  2. Personal Hygiene and Grooming
  3. Oral Hygiene
- B. Dietary Needs
  1. Nutrition
  2. Feeding
  3. Fluids
  4. Diets
- C. Bowel and Bladder
  1. Bathroom Assistance
  2. Bedpan and Urinal Placement
  3. Catheter Awareness

* Report of the Task Force on Comprehensive Recruitment and Employment Training For Adult Care Home Aides as directed by the Kansas State Senate, December 1, 1980.

II. Physical Needs of the Resident (Continued)

D. Proper Method to Align and Move Residents

1. Body Mechanics - lifting
2. Positioning - transferring
3. Restraints

E. Bedmaking

1. Mechanics
2. Bedrails
3. Linen Care

F. Observation of Physical and Behavioral Changes

1. Importance of Observation and Reporting

(a) physical
(b) behavioral

G. Vital Signs--observing but not taking

1. Temperature, pulse and respiration and blood pressure (Limited to certified and licensed employees)

H. Rehabilitation (Restorative)

1. Define
2. Services Available or Offered

III. Psychosocial Needs of the Resident (10 hours)

A. Adjustment to Institutional Life

1. Facility Routine
2. Basic Considerations

(a) What are the emotional needs of the nursing home resident?

self-esteem
affection
security
achievement
individuality
independence
hope

(b) How do you relate to residents with special needs?

ALL behavior has meaning:
the difficult
the non-complaining
the quiet, withdrawn
the verbal abusive/aggressive
the blind or deaf
the exhibitionist
the paranoid

B. Special Problems of the Elderly

1. Adapting to Change

(a) loss of identity
(b) loss of independence
(c) loss of mobility
(d) loss of contact with the everyday world
(e) loss of loved ones
(f) loss of possessions

C. Communications Disorders and Skills

1. Technique needed

(a) loss of vision
(b) loss of hearing
(c) confusion or disorientation

D. Understanding Death and Dying

1. What to do for a dying resident
2. What to do in case of death

E. Importance of Resident Participating in Decision-making and Self-determination

1. Resident Rights
2. Personal Choice
3. Resident Council, Clubs and Associations

Glossary

DECUBITUS ULCERS - sores caused by prolonged pressure on a patient confined to bed for a long period of time.

ECCHYMOTIC AREA - black and blue area.

HEALTH RELATED FACILITIES - residential health care facilities providing health services of a lesser degree than those provided by a hospital or skilled nursing facility.

KWIK HEAT PACK - a chemical pack which produces heat used for treatment.

MEDICAID - a social welfare program established under Title XIX of the Social Security Act which provides medical assistance to low income and certain other medically needy people.

MEDICARE - a social insurance program established under Title XVIII of the Social Security Act which provides hospitalization and other benefits to persons over 65 years of age and disabled persons who are receiving social security benefits. Entitlement to Medicare is not based on need.

NEW YORK STATE HEALTH PLANNING COMMISSION - a state agency with responsiblity for development of health policy for the state.

ORGANIC BRAIN SYNDROME - senility.

PATIENTS RIGHTS - constitutional and other legal rights guaranteed to nursing home residents. See Public Health Law §2803-c.

POSEY VEST - chest restraint for a patient confined to a wheelchair or a bed.

PROPRIETARY FACILITIES - facilities which are privately owned and operated for profit.

RENAL FAILURE - kidney failure

SKILLED NURSING FACILITIES - residential health care facilities providing the highest level of long term care.

STATE HOSPITAL REVIEW AND PLANNING COUNCIL - the New York State council which adopts regulations governing health care facilities, subject to the approval of the Commissioner of Health.

SUBCLAVIAN VEINS - part of the main vein under the shoulder and in the arm.

VOLUNTARY FACILITIES - non-profit facilities which are not privately owned and managed, such as those run by religious or charitable organizations.

END