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VULNERABLE ADULTS: NURSING HOMES, ROOM AND BOARD HOMES

House Bill 4849 (Substitute H-3) House Bill 4933 (Substitute H-2) First Analysis (10-21-93)

Sponsor: Rep. Ilona Varga Committee: Consumers

THE APPARENT PROBLEM:

Sadly, despite periodic legislative efforts to ensure that residents in supervised care settings are properly treated in well-regulated homes or institutions, accounts regularly surface that demonstrate the inadequacies of the system that is supposed to protect adults living in foster care or nursing homes. A recent example arose in early 1992, when media reports brought widespread attention to adult foster care homes owned by Nonya Knox in Inkster and Wayne. Allegations of abuse and neglect at the Knox homes apparently were frequent, but for one reason or another, the homes were not closed until after, as one reporter put it, "one retarded resident became comatose from choking on food and another had almost died from a drug overdose." According to Detroit News accounts, a third resident was left permanently scarred from third degree burns acquired through a scalding, and another developed a severe bowel problem due to an incorrect diet and inadequate medical supervision.

Reports are that the Wayne County Prosecutor's Office investigated the possibility of bringing criminal charges against Ms. Knox, but was unable to do so; apparently a case could not be made for criminal assault, and the law was inadequate to prosecute neglect of an adult. Reports of problems with the Knox homes and other facilities led to the development of an informal task force assembled by the governor and the Department of Social Services (DSS) to investigate the scope of the problem and come up with possible solutions. One outgrowth of that effort was the development of proposals to establish strong criminal penalties for abuse or neglect of "vulnerable adults," and to strengthen penalties in the adult foster care licensing act.

Concerns heightened following deaths last summer in a fire in an unlicensed boarding home in Detroit (the "Pingree Street fire"). Ten people, mostly

elderly or mentally or physically handicapped, died in the fire. The home was a place that had continued to operate as boarding home after losing its license as an adult foster care home. Mental health advocates say that this is a relatively common when regulators shut down an problem: unacceptable adult foster care facility, the operator sometimes maintains it as a room and board. To help address problems with boarding homes, the governor's office ordered development of a model room and board ordinance for adoption by local units of government; the model ordinance gives special attention to fire safety, and is being distributed to local officials. Legislation to incorporate the model ordinance into the state building code has been developed as well. However, if a "room and board" is providing care to adults who need supervision, it falls under adult foster care licensing requirements. conjunction with efforts to properly regulate boarding homes, the law has been examined with an eye to resolving problems with unlicensed adult foster care homes.

Finally, fresh impetus to enact reforms arose following an exhaustive investigative series published by the <u>Detroit News</u> in May 1993. The many stories of abuse and neglect documented in the <u>News</u> series, coupled with accounts of how the system failed to punish or deal effectively with bad operators, brought renewed calls for stiff penalties to deter and punish violators and shut down unlicensed homes.

Legislation to establish special penalties for abuse or neglect of vulnerable adults and to address problems with unlicensed homes has been proposed in the form of House Bills 4716 and 4717, now in the Senate Committee on Health Policy. Additional matters have been left for additional legislation, however: the need for adequate fire safety standards in unlicensed room and board facilities has prompted development of legislation (in the form of House Bill 4933) to place standards in the state construction code act. Further, concerns have been expressed about conflicts between House Bill 4716 (which establishes felony and misdemeanor penalties for several degrees of "vulnerable adult abuse") and the nursing home portion of the Public Health Code (which makes it a misdemeanor for a nursing home licensee, administrator, or employee to abuse or harmfully neglect a patient). Legislation (House Bill 4849) to resolve those concerns has been developed.

THE CONTENT OF THE BILLS:

House Bill 4849 would amend the Public Health Code (MCL 333.21771) with regard to nursing homes to establish penalties for harming a vulnerable adult that were equivalent to the penalties for vulnerable adult abuse in the first, second, or third degree as proposed by House Bill 4716. For a licensee, administrator, or employee to intentionally cause serious physical harm or serious mental harm to a patient would be a felony punishable by up to 15 years in prison, a fine of up to \$10,000 or both (this would be equivalent to firstdegree vulnerable adult abuse). If an omission or reckless act caused serious physical harm, it would be a felony punishable by up to four years in prison. a fine of up to \$5,000 or both (equivalent to seconddegree vulnerable adult abuse). To intentionally cause physical harm would be a misdemeanor punishable by imprisonment for up to two years, a fine of up to \$2,500, or both (equivalent to thirddegree vulnerable adult abuse). (House Bill 4716's fourth-degree vulnerable adult abuse, a one-year misdemeanor, does not have an analogous provision in House Bill 4849.) Terms would be defined much as they are in House Bill 4716.

House Bill 4933 would amend the State Construction Code Act (MCL 125.1508) to require board and room facilities to meet certain fire safety standards paralleling those recommended by the Governor's Committee on Room and Board Facilities. National code standards for property maintenance would be incorporated by reference. Additional provisions would include standards for enclosure of interior stairways, protection of vertical openings, installation of fire alarm systems or smoke detectors (battery operated smoke detectors could be accepted by code enforcers if regular testing, maintenance, and battery replacement was

performed), fire extinguishers, fire resistance for interior finish materials, fire evacuation plans, and bimonthly fire exit drills.

An enforcing agency would have to inspect a facility following a complaint, and would have to issue a compliance order upon finding a violation. An enforcing agency could adopt a schedule of monetary civil penalties imposing up to \$500 for each violation or day of violation. A citation could be issued no later than 90 days after discovery of an alleged violation. An alleged violator could demand an administrative hearing on the matter; the decision of the hearing officer would be final and not subject to appeal. A civil penalty would become final if no petition for a hearing was received within a 20-day deadline set by the bill.

A "board and room facility" would be a residential building that did not provide separate cooking facilities for individual occupants and that was arranged for primarily nontransient shelter and sleeping accommodations for three or more adults. Various facilities, such as college dormitories, bed and breakfasts, and licensed facilities, would be specifically exempted from the definition.

Upon taking effect, the bill would apply to newlyconstructed or -converted board and room facilities. Starting six months after the effective date, the bill would apply to all board and room facilities.

FISCAL IMPLICATIONS:

There is no fiscal information at present. (10-21-93)

ARGUMENTS:

For:

On June 2, 1992, a fire killed ten of sixteen residents of a three-story unlicensed room and board home on Pingree Street in Detroit; various accounts described the victims as mentally impaired, many of them elderly. The fire was serious enough to capture the interest of the National Fire Protection Association, which investigated the fire and issued a report. That report concluded that "the factors that significantly contributed to the loss of life were: the lack of an automatic fire sprinkler system, the presence of combustible interior finish throughout the structure, the lack of fire safety and evacuation training for staff and residents, the presence of open stairways and other unprotected vertical openings, and the lack of a second floor exit

for the second floor." Clearly, if protections such as those proposed by House Bill 4933 had been in place in the house on Pingree, loss of life might have been avoided. Such protections have been recommended as part of a model room and board ordinance drafted by a special governor's committee formed in response to that fire.

For:

One of the criticisms levied against House Bill 4716 is that it would create inconsistency between its proposed criminal sanctions and those that exist under pertinent regulatory acts, especially the nursing home portion of the Public Health Code. House Bill 4849 would address that concern by incorporating various provisions of House Bill 4716 into the Public Health Code. In doing so, the bill would establish a system of escalating penalties for increasingly serious abuses, and replace a woefully inadequate misdemeanor penalty.

Response:

There would be some discrepancies between House Bill 4716 and House Bill 4849; for example, House Bill 4849 does not propose an offense equivalent to fourth degree vulnerable adult abuse as proposed by House Bill 4716, nor does it define "serious physical harm" identically to House Bill 4716. To fully resolve perceived inconsistencies, further amendments may be necessary.

Against:

Various concerns expressed about House Bill 4716 may be applied to House Bill 4849. The legislation proposes severe criminal penalties for certain "omissions," which could include a wilful failure to provide the supervision necessary for a patient's welfare. Thus, the penalties could be applied not only to the actual wrongdoer, but also to a facility owner or administrator who may have had no knowledge of the behavior of an employee. While arguably an owner or administrator should have to share civil liability for any harm that befalls a patient, criminal liability should be reserved for the actual wrongdoer. The bill could unfairly leave a nursing home owner open to criminal charges.

Response:

Nursing home owners and administrators should bear responsibility for failure to adequately select, train, and supervise employees. Whether owners and administrators should be insulated from criminal liability is questionable. Under the bill, for an owner's omission to be subject to criminal sanctions, there would have to be a "wilful failure, or a failure with deliberate disregard of the consequences" to provide certain things necessary for a patient's welfare, and the patient would have to have suffered harm as a result. Someone whose behavior fit this description should be held accountable under criminal law; a civil lawsuit should not be the only legal recourse.

Against:

House Bill 4849 could cause some problems to be hidden. Rather than report problems to authorities, owners and administrators fearful of serious criminal liability might instead try to deal with matters privately. The bills could "chill" self-reporting.

Response:

Many doubt whether the bill would affect the behavior of reputable owners and operators.

POSITIONS:

The Arc Michigan (an organization on mental retardation and other developmental disabilities) supports the bills. (10-21-93)

The Michigan Protection and Advocacy Service supports the bills. (10-21-93)

The Michigan Residential Care Association supports the concept of the bills, but does not have a formal position on them at this time. (10-21-93)

The Department of Public Health is reviewing the substitute for House Bill 4849 and has no position at this time. (10-21-93)

The Office of the Auditor General has no position on the bills. (10-21-93)

The Health Care Association of Michigan is reviewing the substitute for House Bill 4849, and has no formal position on it at this time, but has concerns about it. (10-21-93)