House
Legislative
Analysis
Section

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# ABUSE OF VULNERABLE ADULTS

**House Bills 4716 and 4717 as enrolled**
**Public Acts 149 and 150 of 1994**
**House Committee: Judiciary**
**Senate Committee: Health Policy**

**House Bill 4933 as enrolled**
**Public Act 106 of 1994**
**House Committee: Consumers**
**Senate Committee: Health Policy and Senior Citizens**

**Sponsor: Rep. Ilona Varga**
**Second Analysis (1-26-95)**



## *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 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 a proposal 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 in the summer of 1992 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 problem: when regulators shut down an unacceptable adult foster care facility, the operator sometimes maintains it as a room and board home. 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 regulate room and board homes 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. Thus, in conjunction with efforts to properly regulate boarding homes, the law was 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 Detroit News in May 1993. The many stories of abuse and neglect documented in the News 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.

## *THE CONTENT OF THE BILLS:*

House Bill 4716 would amend the Michigan Penal Code (MCL 750.145m et al.) to create a new chapter dealing with crimes against "vulnerable adults" (that is, adults who because of age, developmental disability, mental illness, or physical handicap require supervision or personal care, or lack the personal and social skills necessary to live independently). The bill would establish the crime of vulnerable adult abuse and distinguish four degrees of it, and establish felony penalties for licensing or rule violations that led to the death of a vulnerable adult. It also would assign misdemeanor penalties to various offenses dealing with misuse of funds, interfering with state investigations, falsifying information, and retaliating against whistleblowers. The bill would take effect October 1, 1994, but could not take effect unless House Bill 4717 was enacted. Further details follow.

Vulnerable adult abuse. It would be vulnerable adult abuse in the first degree if a caregiver intentionally caused serious physical harm or serious mental harm to a vulnerable adult. The offense would be a felony punishable by imprisonment for up to 15 years, a fine of up to $10,000, or both. (Community service also could be ordered for this and the other offenses established by the bill; see below.)

A caregiver or other person with authority over a vulnerable adult would be guilty of vulnerable adult abuse in the second degree if his or her reckless act or reckless failure to act caused serious physical harm or serious mental harm to a vulnerable adult. The offense would be a felony punishable by up to four years in prison, a fine or up to $5,000, or both.

It would be vulnerable adult abuse in the third degree if a caregiver intentionally caused physical harm to a vulnerable adult. The offense would be a misdemeanor punishable by imprisonment for up to two years, a fine of up to $2,500, or both.

A caregiver or other person with authority over a vulnerable adult would be guilty of vulnerable adult abuse in the fourth degree if his or her reckless act or reckless failure to act caused physical harm to a vulnerable adult. The offense would be a misdemeanor punishable by imprisonment for not more than one year or a fine of up to $1,000 or both.

These provisions would not prohibit a caregiver or other person with authority over a vulnerable adult from taking reasonable action to prevent a vulnerable adult from being harmed or from harming another, nor would they apply to an act or failure to act that was carried out in connection with a durable power of attorney for health care.

Deaths due to licensing violations. If an unlicensed facility, employee of an unlicensed facility, or individual acting on behalf of an unlicensed facility intentionally violated the Adult Foster Care Licensing Act or parts of the Public Health Code dealing with hospitals, nursing homes, and homes for the aged, and that violation was the proximate cause of the death of a vulnerable adult, the person would be guilty of a felony punishable by up to five years in prison, a fine of up to $75,000, or both. (In this context, "unlicensed facility" means one that is subject to licensure but is not licensed.)

Other proscribed actions. Certain offenses committed by caregivers, other people with authority over vulnerable adults, or licensees would be misdemeanors punishable by imprisonment for up to two years, a fine of up to $25,000, or both. A repeat offense would be a felony punishable by up to five years in prison, a fine of up to $75,000, or both. (To be subject to the stiffer penalties, a person would not necessarily have to repeat the same offense he or she had committed earlier; the second offense could be any of the listed offenses.) The offenses would be:

** commingling, borrowing, or pledging funds of a resident that are required to be held in a separate trust account;

** interfering with an investigation under the Adult Foster Care Licensing Act, the parts of the Public Health Code dealing with hospitals, nursing homes, and homes for the aged, or the portion of the Social Welfare Act that deals with investigations of reports of abuse, neglect, or exploitation of adults.

** filing false or misleading information required by the Adult Foster Care Facility Licensing Act or the parts of the Public Health Code dealing with hospitals, nursing homes, and homes for the aged.

**intentionally retaliating or discriminating against a resident for giving information to an enforcement official, making a complaint against a facility, or aiding an administrative, civil, or criminal action against a facility.

Such retaliatory action against an employee, if a first offense, would be a misdemeanor punishable by up to one year in jail, a fine of up to $10,000, or both. Second or subsequent offenses would be subject to the same felony penalties that would apply to repeats of the above offenses. The bill would not preclude an employer from taking reasonable and appropriate action against an employee.

Other offenses. A conviction or sentence under the bill would not preclude a conviction or sentence under any other applicable law.

Community Service. In addition to or as an alternative to imprisonment under the bill, the court could impose community service of up to 160 days for a felony or up to 80 days for a misdemeanor. The community service could not involve interaction with vulnerable adults. Someone sentenced to community service could not receive compensation, and would have to reimburse the state or appropriate local unit of government for the cost of his or her supervision.

Definitions. A "caregiver" would be an individual who directly cared for or had physical custody of a vulnerable adult. An "other person with authority over a vulnerable adult" would include, but not be limited to, a person with authority over a vulnerable adult in a hospital long-term care unit. A "facility" would be an adult foster care facility, a nursing home, or a home for the aged. An "reckless act or reckless failure to act" would mean conduct that demonstrated a deliberate disregard of the likelihood that the natural tendency of the act or failure to act would be to cause physical harm, serious physical harm, or serious mental harm. A "vulnerable adult" would be any of the following: an adult who because of age, developmental disability, mental illness, or physical handicap, required supervision or personal care, or lacked the personal and social skills required to live independently; an adult as defined in the Adult Foster Care Facility Licensing Act; or, an adult as defined by Section 11(b) of the Social Welfare Act.

House Bill 4717 would amend the Adult Foster Care Facility Licensing Act (MCL 400.713 et al.) to bar licenses for those convicted of felonies under the act or House Bill 4716; increase penalties for operating without a license, falsifying documents, and other violations of the act; provide for the issuance of emergency licenses; and prohibit certain offenders and those associated with them from being licensed for at least five years following conviction or disciplinary action. The bill could not take effect unless House Bill 4716 was enacted. The bill specifies an effective date of October 1, 1993. Further details follow.

Ban on involvement with facility. The act at present allows the Department of Social Services (DSS) to refuse a license for two years to someone who has had an adult foster care license denied or revoked; such refusals are governed by rules issued under the act. The bill would delete this language and replace it with several restrictions on issuing licenses.

The DSS would be prohibited from licensing someone who had been convicted of a felony under the act or House Bill 4716; that person also would be forbidden from being associated with the ownership or operation of a facility (including residing in a facility).

Someone who had been convicted of a misdemeanor offense under the act or House Bill 4716 would be barred from licensure or other involvement for five years after the conviction. The DSS could, but would not have to, refuse to license for five years someone who had a license revoked or suspended for falsification of documents or for violation of the act, its rules, or the terms of a license. Having a relationship with someone who had a license revoked or suspended also would be grounds for having a license revoked, suspended, or denied for five years after the licensure action. A person would be considered to have a relationship with a former licensee if the former licensee was involved with the facility in any of several specified ways.

Penalties. Operating an adult foster care facility without a license would continue to be a misdemeanor, but the attached penalties would be increased to imprisonment for up to two years, a fine of up to $50,000, or both. A second or subsequent violation would be a felony punishable

by up to five years in prison, a fine of up to $75,000, or both.

At present, it is a misdemeanor to continue to operate an adult foster car facility after the DSS revokes, suspends, or denies a license. The bill would instead make the offense a felony punishable by up to five years in prison, a fine of up to $75,000, or both.

Other violations of the act would continue to be misdemeanors, but the maximum jail term would be increased to one year, and the maximum fine to $1,000.

Operating without a license. If the DSS determined that unlicensed facility was an adult foster care facility, it would notify the owner or operator of the need to be licensed. If the person did not apply for a license within 30 days, he or she would be subject to the penalties that apply to operating a facility without a license (see above).

Emergency licenses. In the case of facilities operated under lease with the Department of Mental Health or a county community mental health board, the DSS could issue an emergency license for a 90-day period to avoid relocation of residents following the revocation, suspension, or nonrenewal of a license, if all of the following requirements were met: the leased facility was in substantial compliance with all licensing requirements; the applicant for the emergency license was a licensee who was in compliance with all applicable regulations under the act and had a contract with the appropriate mental health agency to operate the facility temporarily; and, the former licensee's access to the facility had been lawfully terminated by the owner or lessee of the facility.

Community service. In addition to or as an alternative to imprisonment under the act, the court could impose community service of up to 160 days for a felony or up to 80 days for a misdemeanor. The community service could not involve interaction with vulnerable adults. Someone sentenced to community service could not receive compensation, and would have to reimburse the state or appropriate local unit of government for the cost of his or her supervision.

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 in operating condition could be accepted by code enforcers), 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; the agency could also order the premises vacated. An enforcing agency could adopt a schedule of monetary civil penalties imposing up to $500 for each violation or day of 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 newly-constructed 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:*

The Senate Fiscal Agency (SFA) has reported that House Bills 4716 and 4717 would have an indeterminate impact on state and local government. The new penalties could result in increased costs of incarceration for the Department of Corrections. Given that the bills also would allow for community service and/or fines as a sanctioning alternative, it is difficult to estimate the actual number of violations that would result in prison sentences, although the actual number of increased admissions to the Department of Corrections is not anticipated to be significant. Local units also could incur

increased costs associated with the increased sanctions in the bills. Since the number of annual violations and hence convictions cannot be estimated, however, the actual costs are inconclusive.

The SFA also has reported that House Bill 4933 would not cause a significant increase in workloads of state and local building code enforcement entities. Enforcement actions would potentially include civil penalties, which would be collected and be counted as revenue for the local governmental unit. The amount of local revenue would be determined by the nature of the violation and the number of days that a violation was found to exist without corrective action. The number of violations of this kind and the level of revenue generated by these citations cannot be easily predicted. (3-24-94)

## *ARGUMENTS:*

### *For:*

With deinstitutionalization and the rise in community placement, adults who need care and supervision are supposed to receive that care in well-maintained group or foster homes. However, egregious cases of abuse and neglect of vulnerable adults arise with dismaying frequency. While penalties for neglect or abuse of vulnerable adults are widely perceived to be inadequate, merely hiking penalties in the regulatory acts would be insufficient: licensed settings include a variety of types of facilities regulated by varying agencies, and even licensed settings do not encompass the full range of situations in which vulnerable adults may be living.

To address this situation, House Bill 4716 would do a number of things. It would create the crime of vulnerable adult abuse, which would apply everywhere, regardless of setting; all adults in need of care and supervision would receive equal protection. Thus, the crime would apply not only to the licensed home operator whose careless administration of medication left a resident comatose; it also would apply to an unlicensed operator who left a resident in a scalding bath, to a family member who abused an elderly relative living at home, and to someone who abandoned a mentally impaired family member in a bus station.

House Bill 4716 also would create special felony penalties for unlicensed facilities whose violations of regulatory laws led to the death of a vulnerable adult. Stiff criminal fines would provide a financial incentive not to "cut corners" at the expense of residents; such fines, moreover, are warranted, as some of the worst problems appear to have been with owner/operators who amassed great wealth at the expense of foster care recipients.

Other provisions would address problems experienced with operators who refuse to allow investigators into homes or who bar contact between investigators and residents: obstruction of an investigation and retaliation against whistleblowers (whether resident or employee) would be misdemeanors subject to stiff fines.

In sum, the bill would establish a comprehensive criminal law that would apply across the state. Stiff, uniform criminal penalties should serve to deter and punish wrongdoers; all vulnerable adults in Michigan would benefit as a result.

### *Response:*

A clear problem with the law has been not so much inadequate penalties, which in any event can be addressed through the regulatory acts, but inadequate enforcement. Lack of personnel and funding for inspections, coupled with cozy relationships between some home operators and local agencies, have played a major role in the system's failure to prevent and halt abuse and neglect in adult foster care homes. The bills would do nothing to resolve this root problem.

### *Against:*

Although penalties for retaliating against "whistleblowing" employees or residents would apply to both caregivers and licensees, certain protections would apply to complaints against "facilities," rather than complaints against either caregivers or facilities. It would be better to clarify House Bill 4716 in this regard and ensure the broader protection.

### *For:*

Like House Bill 4716, House Bill 4717 would strengthen criminal penalties applicable to those who abuse or neglect adults who receive foster care, and those who violate licensing laws. However, the bill would further address problems with unlicensed homes by prohibiting certain connections with former licensees; it thus would close the door on those who lose a license, then try to stay in business through other personal or business relationships. House Bill 4717 also would prevent people in residential care settings under the auspices of

community mental health services from being uprooted unnecessarily; the bill offers a mechanism to allow residents to remain while a home changes hands.

***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.