

**Maximizing Your Chances of Avoiding Lawsuits
for Improper Medical or Nursing Care**

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I. WHERE ARE THE SOURCES OF THE LEGAL DUTIES: THE STATUTORY, REGULATORY AND COMMON-LAW FOUNDATIONS:

Operators of assisted living facilities and related institutions are well aware of the oversight imposed by federal and state regulations. Regulatory schemes that provide for periodic surveys of institutions and corresponding systems for noting deficiencies and imposing sanctions are widespread and continue to evolve. In addition to these strictures, common-law principles and various other statutory and regulatory provisions create duties the breach of which may give rise to numerous potential civil claims brought by residents and, in some cases, others who have an interest in the welfare of the resident. The following outline identifies the most common sources of potential liabilities.

A. HEALTH CARE MALPRACTICE CLAIMS

By statute, Maryland law provides a framework whereby those allegedly injured by medical malpractice may seek redress through arbitration and, if necessary, the civil courts. Senior living facilities and related institutions are exposed to medical malpractice claims to the extent they may be considered a statutory “Health care provider.” The Maryland statute regarding health care malpractice claims defines the term “Health care provider” as including “a hospital [and] a *related institution* as defined in § 19-301 of the Health-General Article” Section 19-301 of the Health-General Article in turn defines the term “other related institution” as: an organized institution, environment, or home that . . . [m]aintains conditions or facilities and equipment to provide domiciliary, personal, or nursing care for two or more unrelated individuals who are dependent on the administrator, operator, proprietor for nursing care or for subsistence of daily living in a safe, sanitary, and healthful environment; and . . . [a]dmits or retains the individuals for overnight care.” As can be seen by reference to these definitions, senior living facilities and related institutions should

meet this definition. As a consequence, residents who allege that they have been injured by medical malpractice may take advantage of this statute and bring the appropriate claim with the Director of the Health Claims Arbitration Office.

B. NEGLIGENCE UNRELATED TO THE MEDICAL CARE AND TREATMENT OF THE RESIDENT

Negligence principles ingrained in the Maryland common law provide a basis for numerous potential claims against senior living and nursing care facilities. A large number of these potential claims arise from notions of what has traditionally been referred to as “premises liability.” That is, just as the owner and operator of any business may be presented with an exposure as a result of the existence of a dangerous condition on the premises, so to the owner and/or operator of a senior living facility faces such a risk. Injuries suffered by residents and, under certain circumstances, by those who visit the residents in the facility, and which result from a number of potential hazards created by the premises themselves will be the source of civil claims grounded on negligence principles. Such claims, along with the potential exposures presented by medical malpractice are the most common of the potential risks presented to senior living facilities. Other sources of potential liability include, but are not limited to, the following.

C. MISCELLANEOUS STATUTORY/REGULATORY PROVISIONS WHICH GENERATE THE RISK OF A CIVIL CLAIM.

1. Liability with Respect to Continuing Care Contracts

Section 7 of Article 70B of the Maryland Annotated Code defines the term “continuing care” to include the “furnishing [of] shelter and either medical and nursing services or other health related services to an individual 60 years of age or older not related by blood or marriage to the provider for the life of the individual or for a period in excess of 1 year under a written agreement that requires a transfer of assets or an entrance fee notwithstanding periodic charges.”

Institutions that provide continuing care as defined by this statute are subject to a host of regulations which require, among other things, the registration of the institution with the Maryland Department of Aging, annual reporting meetings open to all of the providers' subscribers, the issuance of disclosure statements to subscribers and prospective subscribers regarding the operations of the facility, and, most important, that specific provisions be included in the agreement between the provider and the subscriber. Section 19 of Article 70B specifically provides that any subscriber, which is defined as the individual for whom a continuing care agreement is purchased, may bring a civil action for the recovery of damages resulting from any violations of the continuing care statutory provisions. Notably, the statutory provision that provides for a civil claim also permits an award of reasonable attorney's fees to a subscriber in whose favor a judgment is rendered. It is therefore critical that institutions that provide "continuing care" agreements be intimately familiar with the compliance requirements of this statutory provision.

2. Liabilities with Respect to the Confidentiality of Medical Records

The disclosure of medical records is very closely regulated under Maryland law. In particular, the disclosure of medical records without the authorization of the person in interest is closely circumscribed by statutory provisions. A violation of these provisions, either by way of the disclosure of medical records without authorization or, under specified circumstances, an unlawful refusal to disclose medical records may result in a civil claim against the facility, its agents, employees, officers and directors. Section 4-309 of the Maryland Health-General Code Annotated specifically provides that a health care provider or any other person who knowingly violates provisions of the statute regarding the confidentiality of medical records "is liable for actual damages."

D. STATUTORY, REGULATORY, OR POLICY VIOLATIONS AS EVIDENCE OF NEGLIGENCE

1. Statutes or Regulations as the Standard of Care

In addition to the aforementioned statutory provisions, there are a host of regulatory schemes established by Maryland law all affecting, as defined by Maryland law, “care homes,” “nursing homes,” “hospice care facilities,” and “assisted living facilities.” An itemization and discussion of these extensive regulations is beyond the scope of this comment. It is worth noting, however, that as a general principle Maryland law provides that the violation of a statute, which is determined to be a cause of a plaintiff’s injuries or damages, may be considered evidence of negligence. That is, although a particular statutory and/or regulatory scheme may not specifically provide for a civil cause of action against the health care provider and/or the related institution, evidence of non-compliance with statutory and/or regulatory requirements may under certain circumstances constitute evidence of negligence and be admissible at a civil trial.

2. Institutional Protocols and Policies as Evidence of the Standard of Care

There is authority in Maryland for the proposition that evidence regarding the protocols or policies of a health care institution may be admissible in evidence at the trial of a claim brought by a patient alleging a breach of the appropriate standard of care. In the case of *Wilson v. Morris*, a 1989 decision of the Maryland Court of Appeals, the Court held that in that particular case, evidence of an adult day care treatment center’s patient monitoring policy was relevant to the jury’s consideration of the appropriate standard of care. Specifically, the Court found that while the policy did not in and of itself establish reasonable standards, it was *probative* in revealing the day care center’s knowledge and perception of its duty to its patients. The strength of this authority suggests various policies with respect to monitoring patient needs may ultimately find their way to a jury

considering a residential institution's alleged failure to properly monitor its residents.

II. Make Your Resident's Best Friend Your Best Friend, Too: Keeping those Likely to Sue Happy With Your Care

1. Identifying People With Standing to Bring a Complaint

One of the worst parts of encountering a problem with a resident is encountering that resident's extended family. Every administrator can tell a story of the incident which brought irate phone calls, letters, and visits from friends and relatives of the resident who had never before even been to visit. Often, it is one of these "interested parties" who then stirs the pot of litigation if a problem can't be resolved. While the staff and administrator can't possibly know and account for all of the friends and loved ones who may genuinely care for the resident and want to see that she gets the best care, it is possible to identify and consistently communicate with those people who either currently do or are likely in the future to speak for the resident.

Looking ahead for the moment, one sees that litigation and complaints to regulators about incidences or conditions in a senior living facility rarely are generated by the resident himself, even if the resident is competent to speak for himself and handle his own affairs. The outsider - a son, daughter, nephew, longtime friend - frequently finds fault with small inconveniences, changes in routine, transient changes in the resident's physical or mental condition, or passing events. These get blown up into grave concerns about the safety of the environment in general and the resident in particular. When that outsider doesn't feel satisfied with the result of his complaints or is dismissed because he doesn't have "standing" to speak for the resident, disaster ensues.

The concept of "standing" is actually a specific legal topic which addresses whether a particular individual has the "right" to press for the relief he is requesting. It generally is a

determination of whether that person has been harmed or stands legally in the position of protecting the rights of someone else who has been harmed. While it seems logical that only the resident or her legally named guardian has standing to object to conditions or request changes, that is not always the case. Moreover, the resident or guardian can still be incited to action by another family member.

Indeed, across the country, standing to sue a senior living facility has been granted not only to legally appointed guardians, but also to legal representatives, advocates, a “resident designee,” a spouse, an adult child, or a “person acting on behalf of the victim with her consent.” It is this broad class of potential plaintiffs which administrators must keep in mind in setting guidelines to avoid litigation.

2. Keeping Interested Parties Actively Engaged in the Care of the Resident

Specifically, the administrator must identify, for each resident, that class of outsiders who are most likely to stand in the resident’s shoes in the event of an incident or to strongly advocate actions on behalf of the resident. These people must be included within the circle of the resident in transmitting information. Of course, this is not to suggest that confidential medical information be shared with those not entitled to such. It is to suggest, however, that each competent resident be given the opportunity to identify family members or friends with whom they do want some or all of their information shared. This can be as narrow as a weekly or bi-weekly status report, which notes any events of importance, or as broad as written consent to permit that family member to review the medical record. A son will be far more likely to trust the judgment, candor, and integrity of a institution simply by knowing that he will always be able to obtain, without undue delay, a medical status report on his mother.

Beyond medical status is the chance to keep outside family members connected to the facility. Most facilities have a weekly or monthly newsletter circulated to its residents. Allow the

resident to designate 3-4 family members and friends to whom the newsletter will be mailed. This gives a constant stream of information to the interested parties, helping them to feel that they know what is happening in the hours and days they aren't there to keep watch. These same 3-4 people should have the opportunity to meet with the social worker or other individualized treatment partner for the resident. An offer of meetings every quarter at which the family members can ask questions and address concerns can be invaluable at keeping lines of communication open. The family members should know that this is the first and one person to whom they can go or whom they can call for a response.

When residents are not competent to name those people who should be kept involved in the facility, ask the legally appointed guardian to do so. In the case of a court appointed guardian, send a standard letter with contact information to all of the interested parties who were identified on the petition for guardianship. As a last resort, take it upon yourself to identify that friend or family member who loyally and consistently visits and cares for the resident.

These are the people who will be first to bring litigation when they feel something has gone terribly, or even only slightly awry. If there has been an open flow of information, however, and these people feel that they have a person to whom to turn for answers, information, and results, many incidences can be resolved.

III. Patient on Patient Violence: Preventing the Hit, Avoiding the Suit

The headlines are filled with stories of abuse and neglect of senior living facility residents at the hands of the reportedly untrained, unprofessional, and sometimes downright criminal staffs. More frequent in incidence, though not as sensational for the papers, however, is the occurrence of one patient hitting another, out of momentary anger, resentment grown from close living quarters,

mental illness, or the development of Alzheimers. Though the causes vary, this is another growing area of interest for attorneys seeking the keys to continued litigation against senior living facilities. Consequently, administrators must build into their risk management program a plan to prevent and react to incidences of patient on patient violence.

1. The Special Care Relationship

The senior living facility puts the resident and the facility in a custodial relationship, in much the same way a school acts toward a student. The facility has not assumed total control of the well-being of the resident. Rather, the resident himself and/or his family and guardian bear considerable control and responsibility for the resident's well-being. Nevertheless, it is frequently only the facility that can intervene in the interactions forced upon one resident by another. The general rule is that a private person (including an institution) is under no special duty to protect another from the criminal acts of a third person unless a special relationship exists between the actor and the third person, or between the actor and the other. The special relationship arises from the setting of the parties, the contractual relationships which may exist, or the duties which may have been assumed by the nature of the interaction.

Senior living facilities, for instance, may fall within the category defined in the law as "Duty of Those in Charge of Person Having Dangerous Propensities." Of course, this pre-supposes knowledge of dangerous propensities, but that knowledge exists the first time that one resident strikes out at another for any reason. Knowledge may be determined from a resident's attempt to injure himself or from her general attitude of belligerence. It probably also exists with regard to any medical diagnosis which includes potentially dangerous propensities, even if the resident has not yet actually manifested such actions. The specific duty then imposed on the facility to exercise reasonable care to control the third person to prevent him from doing such harm.

2. The Steps of Prevention

The obvious first step, then, in minimizing the risk of such incidents, is to clearly identify those patients with a significant likelihood to hit another patient. The information must come from family members, admitting physicians, and current reviews of the resident's diagnosis and prognosis. Once the propensity is identified, all involved staff members must have this information and work it into the treatment plan and observation duties for recording in the patient's medical record. Such recording must go beyond mere reporting that a hit has occurred. It must, instead, include observations of how the resident has handled situations which have made her angry or frustrated or disappointed. Instances of "near hits" must be noted, along with reports of what interventions resolved the scene short of violence. These reports must include episodes involving staff and family members, who are likely to be struck before another patient.

A more delicate, but necessary effort is to counsel those patients who interact with a potentially violent resident. The patient's medical confidences must not be breached, but there must be steps taken to educate others on ways to avoid interactions likely to set off a violent reaction. As in the section above, an imperative is to keep the family members of the potentially violent patient informed and advised of the steps being taken to avoid an incident. Enlist their assistance in identifying catalysts and in offering suggestions on how to mediate interactions with other residents which might result in a hit.

Finally, if the violent encounter occurs, there must be immediate and open candor with the families of both the aggressor and the victim about what occurred, what investigation was undertaken, and what efforts are being undertaken to prevent recurrence. The event must be thoroughly documented, including noting the communications with both families and any objections or complaints made. Avoid the temptation to minimize the effect of the incident if the victim

resident was not badly hurt. It doesn't matter to the family that the hit was minor or the aggression transient. This is one time that "no harm, no foul" doesn't apply. Treat the incident as a serious one and give it that consideration and attention. With regard to the aggressor, no matter how small or fleeting the incident, the facility now has notice that this resident is in the category of "potentially dangerous" and the protocols of handling of that resident must be changed accordingly. Being proactive will prevent the need in many instances or being reactive to litigation.

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APPENDIX

Partial survey of relevant statutes and regulations in Maryland

- A. Medical Records Confidentiality
(Maryland Health General Code Annotated §§4-301, et seq.)
- definition of “records” very broad
 - disclosure requires authorization
 - if no authorization, can only disclose under very specific circumstances
 - penalties for improper disclosure and refusal to disclose
 - criminal penalties: misdemeanor, fine up to \$1,000 for first offense and up to \$5,000 for each subsequent offence
 - civil penalties: liable for actual damages
(Md. Health Gen. Code Ann. §4-309 (c), (d))
- B. Abuse and Neglect
(Maryland Family Law Code Annotated §§14-101, et seq.)
- applies to “vulnerable adults,” defined as an adult lacking “the physical or mental capacity to provide for the adult’s daily needs”
(Md. Fam. Law Code Ann. §14-401(q))
 - not applicable to abuse of adults in a mental health facility, in a facility for mentally retarded individuals, or in a nursing home (they have their own statutory protections)
 - mandates reporting by health care practitioners, police officers, human service workers who has reason to believe that a vulnerable adult has been subjected to abuse, neglect, self-neglect, or exploitation - allows others to report
(Md. Fam. Law Code Ann. §14-302 (a), (c))
 - no penalties enumerated for not reporting
 - generally, identity of person reporting is confidential
(Md. Fam. Law Code Ann. §14-308 (a))
 - immunity from civil liability for reporting and/or investigating a report
(Md. Fam. Law Code Ann. §14-309; Md. Cts & Jud. Pr. Code Ann. §5-622)
- C. Registration of Continuing Care Providers
(Maryland Annotated Code Art. 70B, §7, et seq.; COMAR 14.11.02)

“Continuing Care” defined as: “furnishing shelter and either medical and nursing services or other health related services to an individual 60 years of age or older not related by blood or marriage to the provider for the life of the individual or for a

period in excess of one year under a written agreement that requires a transfer of assets or an entrance fee notwithstanding periodic charges”

(Md. Ann. Code, art. 70B, §7(c); COMAR 14.11.02.01(11))

- requires registration
(Md. Ann. Code, art. 70B, §11; COMAR 14.11.02.03, 14.11.02.06, 14.11.02.09)
- subtitle includes requirements for contracts for continuing care services
(Md. Ann. Code, art. 70B, §13; COMAR 14.11.02.28)
- criminal penalty: violation of subtitle is misdemeanor punishable by imprisonment not exceeding 6 months or fine of up to \$1,000, or both - each violation is a separate offense
(Md. Ann. Code, art. 70B, §18(c))
- civil actions: anyone with a continuing care agreement may bring an action to recover damages for violations of the subtitle, and attorney’s fees may be awarded
(Md. Ann. Code, art. 70B, §19)
- equitable relief: anyone with a continuing care agreement who is injured by a violation of the subtitle may institute an action for temporary restraining order or injunction or may petition for a receiver to rehabilitate, conserve, or liquidate the service provider
(Md. Ann. Code, art. 70B, §20)
- Department of Aging may deny, suspend, or revoke certificate of registration for cause
(Md. Ann. Code, art. 70B, §22; COMAR 14.11.02.35)

D. Hospitals and Related Institutions

(Maryland Health General Code Annotated §§ 19-301, et seq.; COMAR 10.07.01; COMAR 10.07.09)

“Other Related Institution” defined as: “an organized institution, environment, or home that . . . [m]aintains conditions or facilities and equipment to provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependent on the administrator, operator, proprietor for nursing care or for subsistence of daily living in a safe, sanitary, and healthful environment; and . . . [a]dmits or retains the individuals for overnight care”

(Maryland Health Gen. Code Ann. §19-301(l))

- includes “care homes” and “nursing homes”
(Md. Health Gen. Code Ann. §19-307(b))

- requires licensing and provides criteria
(Md. Health Gen. Code Ann. §19-319, et seq.; COMAR 10.07.02.02, 10.07.02.03)
- provides for receivership of nursing homes if unlicensed, or will be closing without making arrangements for residents, or residents have been abandoned, or operation presents imminent danger of death or serious mental or physical harm to individuals
(Md. Health Gen. Code Ann. §19-334)
- provides for rights of individuals in facilities, including knowledge of charges, information on treatment, participation in planning, confidentiality of information, a grievance procedure, privacy, communications, visitors, personal effects
(Md. Health Gen. Code Ann. §19-344)
- provides requirements for discharge and transfer
 - can only be transferred for resident's welfare if needs cannot be met in facility; if resident's health has improved so that services are no longer needed; resident's health or safety is endangered; resident has failed to pay for stay at facility, after appropriate notice to pay given; or facility ceases to operate
(Md. Health Gen. Code Ann. §19-345)
 - penalties include \$10,000 per violation imposed by Secretary of Health and Mental Hygiene or injunctive relief
(Md. Health Gen. Code Ann. §19-345.3)
- provides prohibitions of abuse, defined as "the nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce or resulting in mental or emotional distress
(Md. Health Gen. Code Ann. §19-347(a))
 - mandates reporting
(Md. Health Gen. Code Ann. §19-347(b))
 - penalty for employee not reporting within three days of learning of abuse is civil penalty up to \$1,000
(Md. Health Gen. Code Ann. §19-347(c))
 - provides immunity for making report
(Md. Health Gen. Code Ann. §19-347(g); Md. Cts. & Jud. Pr. Code Ann. §5-374)
- provides penalties for operating a "related institution" without a license or registration permit
 - criminal penalty: misdemeanor, subject to fine of up to

- \$1,000 per day
(Md. Health Gen. Code Ann. §19-358(d)(1))
 - civil penalty: up to \$10,000 per offense
(Md. Health Gen. Code Ann. §19-358(d)(2))
- provides penalties for operating a “related institution” in violation of rules and regulations
 - criminal penalty: misdemeanor, subject to fine of up to \$1,000 per day
(Md. Health Gen. Code Ann. §19-359(a))
 - civil penalty: up to \$10,000 per offense
(Md. Health Gen. Code Ann. §19-359(b))
- provides “intermediate sanctions” (establishment of an escrow account) for uncorrected hazardous conditions (Md. Health Gen. Code Ann. §19-362) that is used to remedy the conditions (Md. Health General Code Ann. §19-363)
- regulations provide requirements for physical environment and patient care
(COMAR 10.07.02)

E. Nursing Homes - Civil Penalties

(Maryland Health General Code Annotated §§ 19-1401, et seq.)

establishes penalties for “deficiencies” in a nursing home

- deficiency is defined as a failure of the nursing facility to meet the requirement of the subtitle and other Medicaid and Social Security regulations, and the condition at issue is serious or life threatening
(Md. Health Gen. Code Ann. §19-1401(b))
- civil penalties may be imposed if there is “clear and convincing evidence of an ongoing pattern of serious or life threatening deficiencies in a nursing facility”
(Md. Health Gen. Code Ann. §19-1402(a); COMAR 10.07.02.45, 10.07.02.46, 10.07.02.47, 10.07.02.48)
- civil penalty may not exceed \$5,000 per day of the existence of the deficiency and may not exceed \$50,000 total
(Md. Health Gen. Code Ann. §19-1405; COMAR 10.07/02.49)

F. Hospice Care Facilities

(Maryland Health General Code Annotated §§19-901, et seq. and COMAR 10.07.21)

G. Assisted Living Facilities

(Maryland Health General Code Annotated §§19-1801, et seq. and COMAR 10.07.14)

“assisted living program” defined as “a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination thereof that meets the needs of individuals who are unable to perform or who need assistance in performing the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for the individuals” - does not include a nursing home, a hospice care program, services provided by family members, or services provided in an individual’s home

(Md. Health Gen. Code Ann. §19-1801(1), (2))

- license is required - different levels of care that can be provided per license
(COMAR 10.07.14.03, 10.07.14.04)
- provides preadmission requirements
(COMAR 10.07.14.09)
- sets forth terms of admission agreement
(COMAR 10.07.14.12, (COMAR 10.07.14.13)
- provides staffing requirements and qualifications
(COMAR 10.07.14.14, 10.07.14.15, 10.07.14.16, 10.07.14.17)
- sets forth services that must be provided
(COMAR 10.07.14.20, 10.07.14.21)
- regulates discharge
(COMAR 10.07.14.24)
- sets forth resident’s rights
(COMAR 10.07.14.26)
- sets forth physical requirements of facility
(COMAR 10.07.14.31, 10.07.14.32, 10.07.14.33, 10.07.14.34, 10.07.14.35, 10.07.14.36, 10.07.14.38, 10.07.14.39, 10.07.14.40, 10.07.14.41, 10.07.14.42, 10.07.14.43, 10.07.14.44, 10.07.14.45)
- provides sanctions for violations of regulations
 - injunctive relief
(COMAR 10.07.14.48)
 - civil penalties of up to \$10,000 per offense
(COMAR 10.07.14.49)
 - criminal penalties
 - operating without a license is misdemeanor with fine up to \$1,000 for first offense and up to \$10,000 for subsequent offenses
(COMAR 10.07.14.50(A))
 - violation of regulations is misdemeanor with fine up to \$1,000 per offense - each day is new offense

(COMAR 10.07.14.50(B))

- emergency suspension of license if emergency action required
(COMAR 10.07.14.51)
- suspension or revocation of license
(COMAR 10.07.14.52)

H. Nursing Home Administrators

(Maryland Health Occupations Code Annotated §§9-101, et seq.)

“Nursing Home Administrator” defined as “individual who administers, manages, or is in general administrative charge of a nursing home”

(Md. Health Occ. Code Ann. §9-101(f); COMAR 10.33.01.02(G))

- license required
(Md. Health Occ. Code Ann. §9-301)
- qualifications listed
(Md. Health Occ. Code Ann. §9-302; COMAR 10.33.01.06)
- examination required
(Md. Health Occ. Code Ann. §9-305; COMAR 10.33.01.09)
- license may be reprimanded, suspended, revoked
(Md. Health Occ. Code Ann. §9-314; COMAR 10.33.01.15)
- prohibits practicing without a license (Md. Health Occ. Code Ann. §9-401); misrepresenting self as licensed (Md. Health Occ. Code Ann. §9-402); license fraud (Md. Health Occ. Code Ann. §9-403); and operating a nursing home without a licensed nursing home administrator (Md. Health Occ. Code Ann. §9-404)
- criminal penalties for violations: misdemeanor with fine up to \$1,000 for first offense, and fine up to \$5,000 and up to 6 months imprisonment for subsequent violations

Survey of standing laws across the United States

ARIZONA

The Arizona Elder Abuse Statute permits the “incapacitated or vulnerable adult” who has been injured by neglect, abuse or exploitation to sue to recover compensatory damages for the injuries they sustain from the abuse. Case law interpreting the statute suggests that only the victim or their legal representative have standing to sue.

See Ariz. Rev. Stat. Ann. § 46-455 (1999); Denton v. American Family Care, 190 Ariz 152; 945 P.2d 1283 (Ariz. 1997).

ARKANSAS

The resident, his guardian or the “resident designee” (if specifically given that right) probably has standing to sue a long-term care facility.

A long term care facility is defined as a “[n]ursing home, residential care facility, post-acute head injury retraining and residential care facility, or any other facility which provides long-term or personal care A resident designee means a person other than the owner, administrator, or employee of the facility designated in writing by a resident or a resident’s guardian if the resident is adjudicated incompetent, to be the resident’s representative for a specific, limited purpose” Ark. Code Ann. § 20-10-1202 (1999).

See Ark. Code Ann. § 20-10-1202 et. seq. (1999).

CALIFORNIA

The Elder Abuse Act allows the abused or dependent adult, as well as his legal representative, to sue for damages arising from the abuse.

Cal. [Welf. & Inst.] Code, Art. 8.5, § 15657, et seq. (1997).

CONNECTICUT

A resident, and presumably his legal representative, has standing to pursue a private cause of action against any “nursing home facility” that negligently deprives a patient of any right or benefit created or established for the well being of the patient under Connecticut’s Patient Bill of Rights.

Conn Gen. Stat. Ann. § 19a-550 (West 2000).

DELAWARE

There is no statutory provision which addresses a private cause of action against a nursing home. Instances of abuse, neglect, mistreatment and/or financial exploitation of residents is addressed by civil and criminal penalties in the Delaware Code.

In the absence of a statutory provision and case law on point, it is likely that a resident and his legal representative would have standing to sue a nursing home and related facilities.

Del. Code. Ann. tit. 16, § 1121 Et. Seq. (1999).

DISTRICT OF COLUMBIA

A resident or the resident's representative may bring an action in court to recover actual and punitive damages for certain violations, including those related to involuntary discharge, transfer, and relocation of the resident and substandard care or facilities.

D.C. Code Ann. § 32-1453 (1986).

FLORIDA

Resident's son, acting as next friend for elderly mother in action for negligence against extended care facility had standing to sue on her behalf even though he had not been appointed her guardian. Pursuant to Florida statutes, an action against a nursing facility may be brought by the resident, his guardian, or by a person or organization acting on behalf of the resident with the consent of the resident. Garcia v. Brookwood Extended Care Center of Homestead, 643 So.2d 715 (Fla. 3rd Dist. Ct. App 1994). See also Fla. Stat. Ann. § 400.023 (West. 1999 and § 400.429.

GEORGIA

Legal spouse has standing to sue nursing facility for negligence and loss of consortium.

Fisher v. Toombs County Nursing Home, 223 Ga.App 842, 479 S.E.2d 180 (1996).

IDAHO

There is no statutory provision which addresses a private cause of action against a nursing home. There is, however, a compulsory pre-litigation panel which must hear claims for personal injury or wrongful death claims for damages arising out of the nursing home's provision of or alleged failure to provide *medical, nursing, or health care services* in the state.

Since this panel exists, it follows that a resident has standing to sue the nursing facility for the damages arising out of the above mentioned acts or omissions. It is not clear whether a party, other than the resident, can bring the action.

Idaho Code § 6-2301 (1999).

ILLINOIS

A resident or his legal representative may bring an action, including a class action, for damages or injunctive or declaratory relief against a nursing home for any intentional or act or omission, committed by the home's agents or employees, which injures the resident.

Ill. Ann. Stat. Ch. 210, § 45/3-601 Et. Seq. (2000).

INDIANA

The case law and statutes are silent on the issue of standing of persons other than the resident.

See Ind. Code Ann. § 12-10-2 et. seq. (West 1999).

MISSOURI

Any resident or former resident who is deprived of any right conferred to him pursuant to the Omnibus Nursing Home Act, may file a complaint with the Attorney General within 180 days of the deprivation or injury. If the Attorney General fails to take legal action within 60 days, then the resident or the executor of the resident's estate may bring a civil action against the facility to recover actual and punitive damages.

Mo. Ann. Stat. §198.093 (Vernon 1999).

NEW JERSEY

Only the resident and his legal representative have standing to sue for the infringement of the resident's rights by an elder care facility. Next of kin do not have standing under the statute.

Profeta v. Dover Shristian Nursing Home, 189 N.J.Super 83; 458 A.2d 1307 (1983). See also Brehm v. Pine Acres Nursing Home, 190 N.J. Super. 103 (1983)(dicta) and N.J.S.A. § 30:13-2 et. seq. (1999).

NEW YORK

The resident or his legal representative has standing to sue any residential health care facility that deprives the resident of any right conferred under the statute. Actions for compensatory and punitive damages, as well as for injunctive and declaratory relief may be maintained.

N.Y. (Public Health) Law § 2801-d (McKinney 1999).

OHIO

One who qualifies as a sponsor of a resident of a nursing home pursuant to Ohio's Nursing Home Patient's Bill of Rights has standing to sue the senior care facility on behalf of the resident. A sponsor is an adult relative, friend or guardian of a resident who has an interest or responsibility in the resident's welfare.

Belinky v. Drake Center, Inc., 117 Ohio.App.3d 497, 690 N.E.2d 1302 (1996). See also, Nursing Home Patient's Bill of Rights, Ohio Rev. Code Ann. § 3721.10 et. seq. (Baldwin 1999).

OKLAHOMA

A resident or his legal representative may maintain an action under the Nursing Home Care Act for any type of relief, including injunctive and declaratory relief, permitted by law.

Okla. Stat. Ann. tit. 63, § 1-1939 (West 1999).

OREGON

“An elderly person or incapacitated person who suffers injury, damage or death by reason of physical abuse or financial abuse may bring an action against any person who has caused the physical or financial abuse or who has permitted another person to engage in physical or financial abuse . . . [a]n action may be brought under the provisions of this section **only by a person who is 65 or more years of age, by an incapacitated person or by a guardian, conservator or attorney-in-fact for a person who is incapacitated or 65 or more years of age.**

Or. Rev. Stat. § 124.100 (1999).

WASHINGTON

A vulnerable adult who has been subjected to abandonment, abuse, financial exploitation, or neglect while residing in a facility has a cause of action for damages on account of his injuries, pain and suffering, and loss or property. The action may be brought by the

vulnerable adult, by his guardian, or by his guardian ad litem.

Wash, Rev. Code Ann. § 74.34 (West 1999).

The Remaining States

As far as the remaining states are concerned, the case law and statutes are silent on the issue of standing of persons other than the resident. Most states, including some of those mentioned above, have criminal and civil enforcement statutes that address elder abuse.

Survey of the law on duty to protect against violence

1. Maryland Case Law

A. Scott v. Watson, 278 Md. 160 (1976). The Court of Appeals addressed the issue of a private person's duty to protect another from the criminal acts of a third person in responding to certified questions from the United States District Court for the District of Maryland. The court adopted § 315 of the Restatement (Second) of Torts which states the general rule that a private person is under no special duty to protect another from the criminal acts of a third person unless a special relationship exists between the actor and the third person, or between the actor and the other.

B. Lamb v. Hopkins, 303 Md. 236 (1985). The court, relying on §§ 315 and 319 of the Restatement (Second) of Torts, found that a probation officer who failed to report a probationer's violation did not owe a duty to an individual injured by the probationer's negligence.

Section 315 articulates the general rule that there is no duty to control the conduct of a third person as to prevent him from harming another person unless a special relationship exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or a special relationship exists.

Section 319, entitled "Duty of Those in Charge of Person Having Dangerous Propensities" states that "one who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."

C. Falk v. Southern Maryland Hospital, 129 Md. App. 402 (1999). The Court of Special

Appeals held that a mental health provider is not liable for the violent behavior of its patient unless it had actual knowledge of the patient's propensity for violence and the patient indicates an intent to harm a specific victim. See Courts and Judicial Proceedings Code Annotated § 5-609, infra.

1. Other States' Case Law

A. Arizona

- (1) Doctor's Hospital, Inc. v. Kovats, 16 Ariz. App. 489, 494 P.2d 389 (1972). Hospital held liable for injuries to patient when he was struck with a chair by another patient who had extricated himself from restraints on at least five prior occasions prior to the time that he slipped out of the restraints and hit patient. His prior behavior, in conjunction with his known hostile attitude, was enough to put the hospital on notice as to the potential dangers that might arise from his actions.

B. Georgia

- (1) Associated Health Systems, Inc. v. Jones, 185 Ga. App 798, 366 S.E.2d 147 (1988). Nursing home held liable for injuries sustained by patient when assaulted by another resident. Nursing home owes its residents a contractual and statutory duty of care and protection to prevent harm to them and a duty of supervision over any resident whose propensity to cause harm to others is known, or should have been known, to management.

C. Illinois

- (1) Bezark v. Kostner Manor, Inc., 29 Ill. App 2d 106, 172 N.E.2d 424 (1961). Nursing home held liable when intoxicated patient injures another patient. Court relies on Restatement of Torts §320.

D. Kansas

- (1) Juhnke v. Evangelical Lutheran Good Samaritan Hospital Society, 6 Kan. App. 2d 744, 634 P.2d 1132 (1981). Patient was assaulted by another patient. Nursing home held liable since it had knowledge of the propensity of the other patient to conduct herself in a belligerent and violent fashion prior to this incident.

E. Kentucky

- (1) University of Louisville v. Hammock, 127 Ky 564, 106 A.W. 219 (1907). Hospital held liable for injuries to patient that were sustained when a demented patient assaulted her. In light of the demented patient's condition, the hospital should have taken reasonable precautions to control and/or confine him in order to prevent injuries to other patients.

F. New York

- (1) Luke v. State, 1 N.Y.S.2d 19 (1937). Overcrowded state hospital found liable for injuries to insane patient since the offending patient was known to be assaultive.
- (2) Rossing v. State, 47 N.Y.S.2d 262 (1944). Overcrowded state hospital found liable for injuries sustained by a patient when he was struck on his head and face by another patient with the arm of a chair. In light of the offending patients' known mental condition and his recorded homicidal tendencies, the state hospital failed in duty to safeguard the injured patient.
- (3) Schoff v. State, 169 N.Y.S.2d 245 (1957). State hospital held liable for injuries to patient when he was knocked down by a minor mental patient who had a known tendency to run about the ward. Hospital should have perceived the potential risk of harm to other patients based on minor patient's prior behavior.
- (4) Miltz v. Ohel, Inc., 627 N.Y.S.2d 891 (1995). Duty to exercise reasonable care to restrain and supervise mentally challenged adult to prevent him from injuring himself or others was on the group home where he had resided for six years prior to alleged attack.

G. Oklahoma

- (1) Harder v. F.C. Clinton, Inc., 948 P.2d 298 (Okla., 1997). Nursing home stands in relationship to its residents similar to that which hospital has in relation to its patients, and has a duty to provide care at a reasonable standard, taking into consideration resident's known mental and physical conditions.

H. Washington

- (1) Funkhouser v. Wilson, 89 Wash. App 644, 950 P.2d 501 (1998). Hospitals' and nursing homes' special relationship with their patients is based on the vulnerability of physically or mentally ill persons to provide care for themselves.
- (2) Niece v. Elmview Group Home, 131 Wash.2d 39, 929 P.2d 420 (Wash., 1997). Group home for developmentally disabled persons owes duty to protect residents from foreseeable consequences of residents' impairments, which includes a duty to protect residents from sexual predators regardless of whether the predators are strangers, visitors, other residents, or employees of the home.

3. Maryland Statutes

- A. Courts and Judicial Proceedings Code Annotated § 5-609, "Mental health care providers or administrators", provides that:

a cause of action may not arise against any mental health care provider or administrator for failing to predict, warn of, or take precautions to provide protection from a patient's violent behavior unless the mental health care provider or administrator knew of the patient's propensity for violence and the patient indicated to the mental health care provider or administrator, by speech, conduct, or writing, of the patient's intention to inflict imminent physical injury upon a specified victim or group of victims.

A "mental health care provider is defined as (1) a mental health care provider licensed under the Health Occupations Article, and (2) any facility, corporation, partnership, association

or other entity that provides treatment or services to individuals who have mental disorders. Cts

& Jud. Proc. Code Ann. § 5-609 (a)(2).

4. Other State Statutes

A. Alabama

- (1) Alabama Medical Liability Act of 1987, Code 1975, 6-5-540 et seq. (This Act applies to a wrongful death action against a nursing home. Crowne Investments, Inc. v. Reid, 740 So.2d 400 (1999)).

B. Georgia

- (1) Bill of Rights for Residents of Long-term Care Facilities, O.C.G.A. §31-8-100 et seq. (This article restricts the actions that a nursing home can take in restraining a resident's mobility, thus inhibiting its ability to protect other residents from an aggressive resident.)
- (2) O.C.G.A. §51-3-1. (Because of special relationship existing between nursing home and its residents, residents must be generally considered invitees of the home; accordingly, as to such residents, nursing home has duty to exercise ordinary care in keeping the premises safe. Pye v. Taylor & Bird, Inc., 456 S.E.2d 63 (1995)).

C. Oklahoma-

- (1) Nursing Home Care Act, 63 Okl. St. Ann §1-1901 et seq.(This Act establishes the standards of care to govern in the nursing home setting, and a nursing home operator's breach of any of those enumerated duties gives rise to a private cause of action under the Act. Morgan v. Calilean Health Enterprises, Inc., 977 P.2d 357 (1998)).