PATIENT NEGLECT IN NURSING HOMES AND LONG-TERM CARE FACILITIES IN NEW YORK STATE: THE NEED FOR NEW YORK TO IMPLEMENT PROGRAMS AND PROCEDURES TO COMBAT ELDER NEGLECT

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INTRODUCTION

The Horden family placed Anne, its cherished family matriarch, into a nursing home knowing it was the only way to ensure she would receive proper care and medical treatment. The Hordens were painfully aware that it would be her home for the rest of her life, because Anne could no longer care for herself. She could not speak as the result of a tracheotomy. She could not walk, because of the extensive amount of time she had spent in bed in the hospital and the damage she had suffered from recent strokes. The Hordens were just thankful she was alive after all of the medical complications she endured over the past few months, and thought the best decision was to place her in the hands of professionals who specialized in providing for patients who needed long-term care. Because of Anne’s tracheotomy, she needed especially frequent attention so that the area surrounding the hole in her neck could

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1 The names have been changed to protect the privacy of the family.
be cleaned and suctioned. The Hordens entrusted Anne’s care to a well-reputed nursing home and rehabilitation facility on the Upper East Side in Manhattan, New York.

However, the nurses in the facility were slow to respond to the family’s requests when Anne needed professional attention, and were inattentive overall. Anne’s sister, children, and grandchildren visited her every day. The lack of attention she seemed to receive at the nursing home did not sit well with them. There was one incident in particular that stood out to the Horden family. During one of her daily visits, Anne’s eldest daughter noticed that her mother was slumped over to one side, and seemed to be exhibiting symptoms of a stroke. When she approached the nurse’s station, the nurses were completely unaware of the situation. They had been so uninvolved with Anne on that day that they had failed to notice that Anne had suffered a stroke. It is hard to fathom how the nurses failed to detect the stroke symptoms when it was their job to be attuned to Anne’s medical needs, hygiene, and comfort.

While the above anecdote presents an extreme example of patient neglect, there are sadly many incidents of neglect in nursing homes and other long-term care facilities. According to the chairman of a National Academy of Sciences panel on elder abuse, neglect is one of the greatest causes of elder maltreatment. Each resident living in a nursing facility has “a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.” Elder rights are of special concern as the baby boom generation approaches the age of retirement because of the much

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larger elderly demographic.\textsuperscript{5} Between the years 2000 and 2030, the elderly population will increase by 101\%, with a projected 71 million people over the age of sixty-five by the year 2030.\textsuperscript{6} With this dramatic increase, there is a greater need than ever to have well-trained and conscientious professionals working in the field of gerontology.\textsuperscript{7}

This Note will address the extent of elder neglect in New York State nursing homes, specifically focusing on the causes of such neglect, the lack of adequate New York and federal legislation to protect the elderly, and proposals for change. As will be explored, elder neglect in nursing homes stems from insufficient care and attention from staff and employees.\textsuperscript{8} There is also a lack of comprehensive state and federal legislation to ensure that the elderly are receiving proper care.\textsuperscript{9} For instance, New York law does not adequately ensure that the employees working in nursing home facilities are the right people for the job.\textsuperscript{10} Laws addressing employee standards and training are crucial because inadequate training is a risk factor for elder maltreatment.\textsuperscript{11} This Note will argue that the current level of care given to the elderly in New York nursing homes and long-term care facilities is unacceptable. The prob-

\begin{footnotesize}
\begin{itemize}
  \item See id.
  \item See discussion infra notes 21-29 and accompanying text.
  \item See Long Term Care Community Coalition, http://www.ltccc.org/key/nursing.shtml (last visited Sept. 15, 2009) [hereinafter LTCCC]. The Long Term Care Community Coalition (LTCCC) is a New York coalition, founded in the 1970s, that works towards improving long-term care for the elderly. Located in New York City, the LTCCC conducts research on nursing homes and strives to increase the levels of nursing home staff, as the organization sees this as the key to a safe nursing home environment. Working with the New York State Department of Health, the Federal Centers for Medicare and Medicaid Services, N.Y. State legislature, the N.Y. State Attorney General, and the Governor’s Office, the LTCCC has also contributed to improvements in federal and state public health codes, regulatory reform, an assisted living law, and to upgraded surveillance and enforcement systems. See Long Term Care Cmty. Coal., About Us, http://www.ltccc.org/about/ (last visited Sept. 15, 2009).
  \item See LTCCC, supra note 9.
  \item CTR. FOR DISEASE CONTROL & PREVENTION, UNDERSTANDING ELDER MALTREATMENT FACT SHEET (2008), http://www.cdc.gov/ncipc/pub-res/pdf/Elder_Maltreatment_Fact_Sheet-08-a.pdf [hereinafter UNDERSTANDING ELDER MALTREATMENT FACT SHEET].
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lem in nursing homes is not only one of abuse, but also of institutional patient neglect.\textsuperscript{12} As the federal and state governments share the role of overseeing the country's nursing homes, both improved federal and New York State legislation is necessary to stop elder neglect in these health care facilities.\textsuperscript{13} This Note will also argue that the means to eliminate neglect is through stricter staffing requirements in nursing homes:\textsuperscript{14} there must be an increased number of employees (with a statewide minimum staffing requirement imposed and enforced in New York), who are both well paid and qualified for the jobs they perform.\textsuperscript{15}

Part I analyzes the scope of the problem, both nationwide and within New York State, and analyzes the quality of New York State nursing home facilities. Part II provides background information on neglect and the federal and New York State initiatives that have taken place in helping states combat elder neglect in nursing homes and long-term care facilities. Part III then turns to the inadequacy of both federal and New York law and programs designed to protect the elderly against institutional neglect. It also explores approaches taken by a few other states, such as California and Florida, and how New York can adopt and greatly improve upon them. Finally, Part IV makes proposals for change in New York.

\textsuperscript{12} See N.Y.C. Alliance Against Sexual Assault, Elder Abuse and the Law Fact Sheet, http://www.svfreenc.org/survivors_factsheet_74.html (last visited Sept. 15, 2009) [hereinafter NYC Elder Abuse Research]. The Alliance explains that "institutional abuse" is usually abuse by an individual who has a "legal or contractual obligation to care for the elderly adult in a nursing home, foster home, or other similar residential facility." \textit{Id.}

\textsuperscript{13} U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES: QUALITY OF CARE MORE RELATED TO STAFFING THAN SPENDING 3 (2002), http://www.gao.gov/new.items/d02431r.pdf [hereinafter NURSING HOME STAFFING].

\textsuperscript{14} LONG TERM CARE CMTY. COAL., POSITION BRIEF: NEW YORK STATE MUST STOP PLACING VULNERABLE PEOPLE INTO THE STATE'S MOST SEVERELY UNDERSTAFFED NURSING HOMES 1 (2008), http://www.ltccc.org/key/nursing.shtml (follow "Click here for policy brief: NY State Must Stop Placing Vulnerable People into the State's Most Severely Understaffed Nursing Homes" hyperlink) [hereinafter POSITION BRIEF]. This brief was written in support of the Nursing Home Division Act (NHDA) bill # A5347. Long Term Care Cmty. Coal., Nursing Homes, http://www.ltccc.org/key/nursing.shtml (last visited Sept. 15, 2009). The bill amended sections 2807-c and 2807 of the public health law to upgrade the Medicaid reimbursement system for diagnostic and treatment centers so that it would be based on reasonable costs, like the system for Medicare reimbursement for critical access hospitals. Assem. B. A5347, 2009 Leg. (N.Y. 2009).

\textsuperscript{15} See discussion \textit{infra} Part I, pp. 185-90.
I. Scope of the Problem Nationwide and in New York State

Unfortunately, Anne’s story is just one example of the ongoing problem of patient neglect in nursing homes and long-term care facilities in the United States today. A 2004 Survey of State Adult Protective Services, funded by the U.S. Administration on Aging ("AoA"), a division of the Department of Health & Human Services, reported that there was a 19.7% increase in reports of elder and vulnerable adult abuse and neglect from 2000 to 2004, and a 15.6% increase in substantiated cases.\(^\text{1}\) This enormous increase over the course of a four-year period does not bode well for the level of care the elderly population in the United States can expect in the future unless steps are taken to remedy elder abuse and neglect. Such measures are especially necessary as the baby boomer generation reaches the age of retirement.\(^\text{17}\)

While the quality of nursing homes, the care they provide, and their regulation have greatly improved since the 1960s and 1970s,\(^\text{18}\) there is still a great deal of abuse and neglect in these New York State facilities.\(^\text{19}\) In trying to improve the standard of care in these nursing homes and long-term care facilities, the first step is to determine the scope of the problem; that is, why patient neglect exists in these health care facilities.\(^\text{20}\) It is only once the causes of neglect are properly identified that federal, state, and local legislation can be drafted that will accurately address the key problem areas, and then enforcement measures can be taken.

There are many possible reasons why the elderly are neglected in health care facilities. With no minimum number of staff required in

\(^\text{16}\) See U.S. Admin. on Aging, Dep’t of Health & Human Serv., Nat’l Ctr. on Elder Abuse Program Announcement and Grant Application Instructions (2006), http://www.aoa.gov/Grants/Funding/docs/2006/Attachment_1373.doc (last visited Aug. 25, 2009). The AoA is the federal agency that advocates for elderly Americans. Part of its role is to increase awareness for other federal agencies on both the contributions and concerns of the elderly. See Admin. of Aging, Dep’t of Health & Human Serv., About Us, http://www.aoa.gov/AoARoot/About/index.aspx (last visited Sept. 15, 2009).

\(^\text{17}\) See supra text accompanying notes 5-6.


\(^\text{19}\) See Long Island Investigation, supra note 2 and accompanying text.

\(^\text{20}\) See discussion infra notes 87-90 and accompanying text.
New York State nursing homes, inadequate elder care often results from understaffing of nurses, underpaid aides with poor training, and rapid turnover of aides and nurses. Because of understaffing, employees are frequently overworked, making it nearly impossible for them to provide proper care. Without enough nurses, some aides perform services for which they are not trained, such as dispensing medications, suctioning patients, and inserting catheters, which are duties that should only be performed by licensed doctors and nurses. When untrained aides take on these jobs, the result is improper administration of care to residents. Over ninety percent of institutional caregivers are not properly trained and “have little or no nursing experience.” These circumstances place a great deal of stress on caregivers, who are unable to cope because they do not have the necessary skills and resources, and leads to homes that are unsafe for residents. Proper staffing is therefore the key to a nursing home environment with residents who are safe and well cared for.

\[21\] See Position Brief, supra note 14, at 1. According to the LTCCC Position Brief, each year a bill is introduced in Albany to require minimum staffing in New York State nursing homes, but each year it fails. See id. While there is no such requirement in New York, each health care facility operating under the New York Public Health Law must submit a report to the New York Department of Health, which includes information on staffing in the facility as part of the health care facility inspection process. See N.Y. Comp. Codes R. & Regs. tit. 10 § 412.1 (2009). The New York State Compilation of Codes, Rules, and Regulations only provides that “[n]ursing homes . . . shall provide such care and services in a manner and quality consistent with generally accepted standards of practice.” N.Y. Comp. Codes R. & Regs. tit. 10 § 415.1(b)(1) (2009).


\[23\] See Polisky, supra note 22, at 385-86.


\[25\] See id. at 6-7.

\[26\] Polisky, supra note 22, at 385.

\[27\] Id. at 385-86. Nursing home employees are frequently placed in situations where there are too few employees to adequately care for the residents, and many are untrained for the tasks they are asked to perform. This combination leads to a high level of stress that then leads to abuse. Id. at 386.

\[28\] See id.

\[29\] See id.
Furthermore, unlicensed aides are paid less than janitors on a weekly basis.\(^3^0\) Since aides are paid so little, they lack the desire to stay in these positions, resulting in frequent turnover.\(^3^1\) With new aides constantly coming in and out of nursing homes, they feel little attachment to the residents.\(^3^2\) New York needs to provide increased funding so that aides are better paid, thereby reducing the high turnover rate and motivating them in their work.\(^3^3\) A study performed by the Subcommittee on Health and Long-Term Care revealed that many caregivers did not actually perform any work during their working hours, and some were even intoxicated or under the influence of drugs.\(^3^4\) It is frightening that some aides, with no medical training, are administering medications or are intoxicated or high while working with often helpless residents who are unable to realize that they are not receiving proper care.

Since the cost of a resident staying in nursing homes in the New York City metropolitan area is one of the highest in the nation,\(^3^5\) with room rates averaging approximately $323 per day,\(^3^6\) there is little excuse for why these homes are understaffed and have poor problem identification, inspection, and complaint systems. Logically, it would make sense for these homes to be some of the highest rated in the country. Instead, they are understaffed and have many reported cases of neglect.\(^3^7\) The New York Post reported in 2006 that dozens of New York City nursing homes are “houses of horrors.”\(^3^8\) Residents of these homes “die from shoddy care, women are sexually abused and lax security endangers dementia sufferers who wander.”\(^3^9\) The Post reported that forty-

\(^{30}\) Id. at 385.
\(^{31}\) See id.
\(^{32}\) See id.
\(^{33}\) See id.
\(^{34}\) Id.
\(^{36}\) See N.Y. State Dep’t of Health, Estimated Average New York State Nursing Home Rates, http://www.nyhealth.gov/facilities/nursing/estimated_average_rates.htm (last visited Sep. 15, 2009) (listing the estimated average cost per day and per year of New York State nursing homes by region).
eight of the city’s homes violated the State Health Department’s regulations and that eight homes were in such dismal shape that they were at risk of being shut down as a result of below average quality of care. If the residents’ money is not going into these systems, then where is it going?

Unfortunately, these difficulties are not limited to nursing homes in New York City. A study conducted by the Long Term Care Community Coalition (LTCCC) in 2006 revealed that nursing homes in all regions of New York State fell below the national average in identifying problems related to care. Before all residents can receive the level of care they require and to which they are legally entitled, it is first essential to identify the specific problems in each nursing home and their source. Without inspection, identification, and complaint systems that accurately account for instances of neglect, it will no doubt be difficult for the New York State Department of Health (DOH) to fix these problems. Some examples of neglectful deficiencies identified by the LTCCC study include: not serving food at proper temperatures; failing to respond to emergencies; not ensuring that the level of care met professional standards of quality; not making sure residents were released from restraints that were only meant for convenience or discipline; errors in administering medication; not fully informing a resident about the cancellation of surgery; not keeping the home free from accident hazards; not thoroughly investigating symptoms that indicated possible elder abuse; poor respiratory treatment and care; and sub-par services relating to the residents’ physical well-being, injury prevention, and supervision.

In 2008, the federal government instituted a new ratings system for nursing homes based on a five-star scheme. The system is based on

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40 Id.  
43 See Rudder & Shineman, Nursing Home Oversight, supra note 41, at 21-25.  
criteria such as staffing, quality of care, and statewide inspections. While the five-star system may be helpful to families in selecting a nursing home, it is puzzling why homes given only one star are allowed to remain open in their current operating condition. It is also hard to fathom how a system that bases its quality of care on a comparison of the number of bedsores, for example, is socially acceptable and legally permissible. The standard of care should be set at a bar where residents are comfortable and bedsores free, not one where homes with residents having fewer bedsores are considered the best. Bedsores are preventable if patients are properly handled from the outset.

Patient neglect has become so egregious in recent years that the New York State Attorney General, Andrew M. Cuomo, has been placing hidden surveillance cameras in various nursing homes around the state. Cuomo’s office is leading the country in investigations into the care of the aged and vulnerable elderly population. The hidden cameras have revealed many instances of neglect, including two licensed practical nurses and two certified nurse aides in a Long Island nursing home in Medford, New York, not tending to a resident who needed assistance with all of his daily activities. The Medford tape revealed “conduct that endangered the resident.” The nurses failed “to move and turn over the patient for hours on end, denied him water and left him sitting in his own waste for nearly a full day.” Cuomo made a public statement stressing the importance of stopping elder neglect:

[My] message is clear: my office is watching like a hawk when it comes to the treatment and care of New York’s most vulnerable patients and will not tolerate the kind of disturbing neglect and abuse we’ve witnessed . . . . This is the fourth time our hidden-camera surveillance has revealed despicable cases of callous and life-threatening patient treatment at nursing homes across the state.

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45 See id.
46 One star indicates “much below average” care where a high percentage of residents suffer from bedsores, for example. Id.; see also infra note 207.
48 See Long Island Investigation, supra note 2 (describing the revelation of patient neglect as seen on hidden surveillance cameras).
49 Id.
50 See id.
51 Id.
52 Id.
53 Id.
Elder neglect, in addition to abuse, may result in criminal liability.\(^\text{54}\) For instance, the neglect spotted through the tapes in the Medford nursing home resulted in the arrest of the nurses.\(^\text{55}\) They were charged with “endangering the welfare of a physically disabled person” and “falsifying business records” to cover up the neglect.\(^\text{56}\)

II. THE BACKGROUND AND HISTORY ON ELDER NEGLECT

A. Neglect Defined

Neglect is defined as “[t]he omission of proper attention to a person or thing, whether inadvertent, negligent, or willful; the act or condition of disregarding.”\(^\text{57}\) The Older Americans Act of 2006 defines neglect in the context of elder care as “the failure of a caregiver . . . or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an older individual.”\(^\text{58}\) The Code of Federal Regulations (C.F.R.) also defines patient neglect.\(^\text{59}\) According to the C.F.R., patient neglect is “the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.”\(^\text{60}\) It defines “[s]ubstandard quality of care” as care having

one or more deficiencies relat[ing] to participation requirements, . . . [r]esident behavior and facility practices, . . . [q]uality of life, or . . . [q]uality of care . . . which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.\(^\text{61}\)

Mistreatment of the elderly not only consists of elder abuse, but also elder neglect.\(^\text{62}\) Under the federal standards, Anne did not receive adequate care — she was neglected by the nursing home where she re-

\(^{54}\) See id.
\(^{55}\) See id.
\(^{56}\) Id.
\(^{57}\) BLACK'S LAW DICTIONARY 478 (3d ed. 2006).
\(^{59}\) 42 C.F.R. § 488.301 (2009).
\(^{60}\) Id.
\(^{61}\) Id.
The failure of trained professionals to notice symptoms of Anne's stroke, when the untrained eye was able to observe them within seconds of seeing her, reflects a level of care that falls well below that required by the C.F.R. and the Older Americans Act. The chances of Anne's recovery from her stroke were severely diminished by this lack of attention because it is essential to stroke victims' recovery that they receive immediate medical attention.

B. Federal and New York State Attempts to Eliminate Elder Neglect in Nursing Homes: Combating Elder Neglect from the Top Down

The C.F.R. promulgates regulations that are “[r]equirements for states and Long-term Care Facilities.” Under the regulations, “[a] facility must protect and promote the rights of each resident.” Additionally, long-term care facilities must sustain an environment that maintains or promotes the residents’ quality of life and a level of care such that the residents receive the necessary services to achieve the highest possible “physical, mental, and psychosocial well-being.” Furthermore, residents who are unable to carry out their own basic daily activities must receive the care and attention necessary “to maintain good nutrition, grooming, and personal and oral hygiene.”

The problem with institutional elder care dates back to the rapid growth of the availability of nursing home beds in the 1960s and 1970s. While many beds were made available through public funds during the 1960s, there was very little federal government supervision of nursing homes at the time. The federal government set minimal standards for homes receiving payments from Medicare and Medicaid, and the states were then free to expand upon these regulations.

63 See Older Americans Act Amendments of 2006 § 101; see also 42 C.F.R. § 488.301.
64 See supra notes 58-61 and accompanying text.
70 Id.
72 See id.
73 See id.
eral standards were lower than any of those implemented by the states. Until the Nursing Home Reform Law was passed in 1987, federal oversight of nursing homes was nominal. While every state’s standards were better than the federal standards, the quality of New York’s nursing homes was still far from acceptable. In the 1970s, the media exposed the appalling nursing home conditions, including many instances of neglect. The New York State Department of Health responded by assuming the responsibility of regulating and surveying the state’s nursing homes. Since then, there has been greater oversight of New York’s nursing homes.

It is not easy to pinpoint why there is such a high rate of elder neglect in New York State nursing home facilities today. To effectively solve this increasing problem, the federal government must take a strong stance against elder neglect, and must work with the states to increase the hiring criteria in nursing homes, provide better training for nurses and aides, increase pay, and continually emphasize caregivers’ responsibilities. Therefore, the federal government must take a hard line against elder neglect. Unfortunately, these issues do not receive nearly as much attention as other federal concerns such as child abuse and domestic violence. Not only does the federal government fail to take elder neglect as seriously, but the issue also receives less media attention, resulting in an overall shortage of public awareness.

The lack of federal attention is a major hindrance to ensuring that the elderly receive proper care. There are, however, two federal offices of Elder Justice currently in place, one at the Department of Health and Human Services, and the other at the Department of Justice. Their purpose is to develop programs and public policies, propose grants, and

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74 See id.
75 See id.
76 See id.
77 See id.
78 See id.
79 See id.
82 See id. at 223.
83 See id.
84 See id. at 208.
assist in efforts to address elder neglect, abuse, and exploitation. However, as of 2003 not one federal employee worked full-time on these issues. While the federal government has defined elder neglect and abuse, and set out broad rules and regulations, there is still no comprehensive federal legislation addressing elder abuse and neglect. For individual states to successfully combat and prevent elder neglect, it is essential that there be a "coordinated," guided approach at the federal level.

United States Senators John Breaux and Orrin Hatch, who served on the U.S. Special Committee on Aging at the Department of Health and Human Services, recognized this problem, and saw the necessity for a "multifaceted solution," one that combined involvement from public health, social service, and law enforcement departments, and included coordination between these entities. They saw the problem as stemming from a lack of research, reporting, and funding. The Senators argued that without Congress leading the way and taking steps to first assess the actual scope of the problem, it would be harder for states and local communities, who have fewer resources, to take their own initiatives at the state and local levels.

Senators Breaux and Hatch made a series of proposals in 2003 to improve elder care. These proposed strategies included the following:

* providing better information to the public;
* increasing research and funding;
* developing forensic methods to detect signs of abuse and neglect;
* creating "safe havens" for the elderly who are not safe in their homes;

85 See id. at 209-10.
86 See id. at 208.
87 See National Council on Aging, supra note 80 (explaining the importance of a federal initiative in combating elder abuse and neglect).
88 Id.
90 Breaux & Hatch, supra note 81, at 208-09.
91 See id. at 209.
92 See id. at 208.
93 See id.
94 See id. at 209-12.
• increasing the skills of local, state, and federal law enforcement in policing, detecting, investigating, and assisting victims through better training;
• developing special programs for underserved communities of senior citizens;
• developing model state laws and practices to help Congress evaluate whether any future legislation would be useful based on successful existing state laws and practices;
• increasing security measures;
• improving staffing methods in nursing home facilities;
• establishing a long-term care consumer clearinghouse that would help families choose the best long-term care options; and
• “promoting collaboration” between these initiatives.95

Finally, Congress responded in 2007 by proposing the Elder Justice Act.96 The Act was a bipartisan initiative to set a federal standard for states to follow in working to eliminate elder abuse and neglect.97 Among the Act’s goals were to create federal funding for State Adult Protective Services (APS), ensure that the Department of Health and Human Services (HHS) provides an office for APS support within each state, and create initiatives to help states reduce the elder neglect in their nursing homes and long-term care facilities.98 Unfortunately, the bill did not pass in either the House of Representatives or the Senate.99

The Elder Abuse Victims Act of 2008 was another congressional attempt at passing federal legislation that would work towards eliminating elder abuse and neglect.100 It was introduced in the House of Representatives in February 2008.101 The bill proposed the allocation of $315 million primarily to state and local governments between the years 2009 and 2015 for the purpose of combating elder abuse.102 Among other things, the Act “require[d] the Attorney General to research State laws and practices relating to elder abuse, neglect, and exploitation; develop objectives, priorities, policies, and a long-term plan for elder justice pro-

95 Id. at 212.
97 See id.
98 See id.
101 See id.
grams and activities; and report its findings."\textsuperscript{103} Although this bill achieved more success than the 2007 Elder Justice Act because it passed in the House of Representatives,\textsuperscript{104} it was rejected in the Senate.\textsuperscript{105}

III. THE INADEQUACY OF THE NEW YORK STATE AND FEDERAL LEGISLATION ADDRESSING ELDER NEGLECT

Congress enacted the Older Americans Act of 1965 (OAA) on July 14, 1965.\textsuperscript{106} In enacting the Act, Congress's purpose was

\[\text{[t]}\text{o provide assistance in the development of new and improved programs to help older persons through grants to the States for community planning and services and for training, through research, development, or training project grants, and to establish within the Department of Health, Education, and Welfare an operating agency to be designated as the "Administration on Aging."}\textsuperscript{107}

In its current form, the Act makes it the United States government's responsibility to assist the elderly in achieving "suitable housing," "long-term care services," and in obtaining "[f]ull restorati[on] services for those who require institutional care."\textsuperscript{108} The OAA emphasizes that it is the federal government's duty to ensure that the elderly receive proper services and assistance, and live comfortably, safely, and with dignity.\textsuperscript{109} Furthermore, the AoA was established to supervise, at the federal level, the creation and implementation of the OAA's programs.\textsuperscript{110} Federal measures under the AoA, such as the Vulnerable Elder Rights Protection Program established in 1992, promote laws addressing statewide concerns about elder neglect, as well as provide legal assistance to the elderly in pursuing such claims.\textsuperscript{111}

\textsuperscript{103} Id. at 11.
\textsuperscript{104} See Telephone Interview with Katy Bosse, supra note 99.
\textsuperscript{105} See id.
\textsuperscript{107} Id.
\textsuperscript{109} Id.
\textsuperscript{110} See Admin. on Aging, Dep't of Health & Human Serv., Elder Rights: Safeguards for the Most Vulnerable Among Us 1 (2009), http://www.aoa.gov/AoAroot/Press_Room/Products_Materials/pdf/Elder_Rights.doc.
\textsuperscript{111} See NYC Elder Abuse Research, supra note 12.
While these federal legislative enactments have the right idea in trying to oversee and implement statewide programs to protect the elderly from abuse and neglect, they are insufficient in practice. The inadequacy of these laws can be seen through the nationwide rise in the number of reports of abuse and neglect in recent years. While Congress has held hearings for over twenty-five years attempting to address elder abuse, no bill has been passed that provides adequate protection for the elderly.

The process of trying to eliminate elder neglect in nursing homes and long-term care facilities currently begins with state personnel known as “surveyors” assessing the weaknesses in each home that needs correction. These surveyors identify problems unique to each home through “regular state inspections and through investigations of consumer complaints” based on state and federal standards. These deficiencies are then rated on a scale in terms of their severity and scope. The criteria for severity are based on inquiries of the administration into the level of real or potential harm to residents. The ratings for scope are then evaluated based on the number of residents who are “potentially or actually affected,” the degree of harm likely to be caused to the residents, whether the harm reflects a pattern or an isolated incident, and whether the harm has in fact occurred. The structure of this process is problematic itself in that it is unlikely for nursing home administrators to be completely forthcoming with their homes’ shortcomings, especially if they had a hand in the deficiencies.

A 2005 report by the LTCCC indicated that New York, compared to other states, did not do as good a job of identifying and rating deficiencies. Specifically, “[New York State wrote] fewer deficiencies per

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112 See National Council on Aging, supra note 80.
113 See id.
114 See id. and accompanying text.
115 RUDDER & SHINEMAN, NURSING HOME OVERSIGHT, supra note 41, at 5. Typically, surveyors identify things such as “the use of physical restraints, the incidents of pressure sores... the rate of medical errors, the adequacy of the nursing staff, the maintenance of residents’ quality of life and personal dignity, the facility’s cleanliness, and the thoroughness of employee background checks.” NURSING HOME STAFFING, supra note 13, at 3 n.5.
116 RUDDER & SHINEMAN, NURSING HOME OVERSIGHT, supra note 41, at 5.
117 See id.
118 See id.
119 Id.
120 See id. at 6; see also RUDDER ET AL., FAILURE OF SURVEY & COMPLAINT SYSTEMS, supra note 42, at 3.
facility than 38 other states and [found] more of its facilities deficiency-free than 36 other states.”121 To solve the deficiencies, it is first necessary to properly locate and identify them.122 Section 5(b) of the 2007 Elder Justice Act, “National Training Institute for Surveyors,” was an attempt on the federal level to improve statewide surveying through grants to state agencies and better surveyor training.123 While this provision would have provided resources for New York to improve its statewide surveying system, it did not pass the Senate.124

While research conducted by the United States General Accounting Office (GAO) in 2002 indicated that “oversight [of nursing homes] by federal and state authorities has increased[,]”125 the number of nursing homes in the United States with deficiencies that place residents “at risk of death or serious injury” still accounts for thirty percent of the country’s 17,000 nursing homes.126 This percentage is frighteningly high. While nursing home oversight may have increased and improved since the nursing home scandals in the 1970s,127 nursing home practices are still not being supervised closely enough if such a high percentage of homes continue to pose dangers to their residents. Thus, the federal government also needs to do its part to ensure that homes are providing proper care.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency in charge of ensuring that states comply with federal standards for the quality of care given to nursing home residents.128 CMS works with the states’ agencies and inspects nursing homes that partici-

121 See RUDDER ET AL., FAILURE OF SURVEY & COMPLAINT SYSTEMS, supra note 42, at 3. An additional problem with “the survey process” is that “surveyors may apply standards unevenly” since it is a subjective process. NURSING HOME STAFFING, supra note 13, at 4. Therefore, under the current surveying system, it is difficult to accurately assess and compare deficiencies across states. See id.
122 See RUDDER ET AL., FAILURE OF SURVEY & COMPLAINT SYSTEMS, supra note 42, at 3-4.
124 See Telephone Interview with Katy Bosse, supra note 99.
125 Many Shortcomings Exist in Efforts to Protect Residents from Abuse: Testimony Before the Special Committee on Aging, U.S. Senate, 1 (March 4, 2002) (statement of Leslie G. Aronovitz, Director, Health Care, Program Administration and Integrity Issues) [hereinafter Aronovitz, Shortcomings], available at http://www.gao.gov/new.items/d02448t.pdf; see also NURSING HOME STAFFING, supra note 13, at 3.
126 Aronovitz, Shortcomings, supra note 125, at 1.
127 See ELDER LAW HANDBOOK, supra note 18, § 10:1.
128 See U.S. GOV’T ACCOUNTABILITY OFFICE, NURSING HOME DEATHS: ARKANSAS CORONER REFERRALS CONFIRM WEAKNESSES IN STATE AND FEDERAL OVERSIGHT OF QUALITY OF CARE 9 (2004); see ELDER LAW HANDBOOK, supra note 18, § 10:1.
pate in Medicare and Medicaid.\footnote{129} It “investigate[s] complaints of inadequate care” in addition to complaints of abuse.\footnote{130} CMS focuses on the practices surrounding the hiring of employees and requires certain, albeit vague, nurse staffing requirements.\footnote{131} Additionally, CMS requires that nursing homes do not hire employees who were previously convicted of elder abuse.\footnote{132} This type of required background investigation is just the beginning in setting the standard for the hiring of nursing home employees. For example, applicants who were convicted of offenses that occurred outside of nursing homes are not kept from being hired.\footnote{133} Furthermore, these routine background investigations are only made statewide, so prospective employees guilty of crimes outside of the state where they are applying may be hired even if they would have been kept from working in a nursing home had the crime been committed in-state.\footnote{134} These requirements are therefore insufficient to ensure that the employees who are hired are high-quality caregivers (and not criminals).

Since nurse aides are the primary caregivers to nursing home residents, federal law requires states to maintain registries listing aides who have completed training and competency evaluation programs.\footnote{135}

\footnote{129} See Aronovitz, Shortcomings, supra note 125, at 3.
\footnote{130} Id.
\footnote{131} See Minimum Staffing Ratios, supra note 22, at 2. The general minimum staffing requirement under the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) is that nursing homes must provide sufficient staffing levels so that the facilities maintain the resident’s well-being. Id. Under this requirement, registered nurses must be available for eight hours of the day, and licensed nurses for twenty-four hours. Id. However, these numbers are the same regardless of whether the nursing facility has 60 or 600 beds and is therefore argued as being inadequate by many professionals in the field. Id. Instead, it is suggested that there be a ratio of nurses to residents. See id. The reports made by the Department of Health and Human Services (HHS) indicate that there is a strong relationship between the ratio of staff to residents in nursing homes and the quality of care residents receive. Id. at 8. However, this report qualifies its findings, noting that the HHS does not believe that there is enough information yet to impose a federal requirement on all Medicare and Medicaid certified nursing homes. Id. at 10. Further studies are first needed. See id. at 8-11. A later GAO report did reveal that nursing homes in Ohio and Washington State that had higher ratios of nursing hours per resident each day were less likely to have “repeated serious or potentially life-threatening problems as measured by deficiencies detected during state surveys.” Nursing Home Staffing, supra note 13, at 2.
\footnote{132} See Aronovitz, Shortcomings, supra note 125, at 3.
\footnote{133} See id.
\footnote{134} See id. at 9.
\footnote{135} See id. at 4. There are problems, however, with the registries and this qualification system. For instance, not all nurses are subject to this training and competency evaluation. There may be exemptions from training, for example, in cases of student nurses or aides trained in countries other than the United States. See id. at 4 n.4. Another problem with the registries is
These registries also list any reported instances of neglect, abuse, or theft by applicants.136 While nursing homes are required to check the registries when making employment decisions, aides are allowed to work in nursing homes for up to four months while completing training and evaluation programs.137

Neglect may be unintentional.138 Poor training may lead to such inadvertent neglect.139 During the four-month training and transition period, untrained and inexperienced aides may unknowingly neglect residents. Aides should be required to complete a training program and pass a competency evaluation before they are allowed to work unsupervised with the residents. This requirement would likely help eliminate many instances of unintentional neglect. At the very least, untrained aides should be supervised at all times when working with the elderly.

The Medicare and Fraud Control Unit (MFCU) is the law enforcement agency that investigates claims of patient neglect and abuse.140 There is an MFCU in every state.141 Unfortunately, MFCU investigations are not automatic—the MFCU only becomes involved when it receives referrals from state survey agencies, which vary by state.142 MFCU investigations are also triggered if criminal charges are brought against nursing homes.143 In New York, it is the State Health Depart-

that nursing homes only receive quarterly updates of disqualified aides within their state. See id. at 4 n.5. Aides therefore may become disqualified and continue to work in homes for months without supervisors knowing any differently. Additionally, state agencies define elder abuse differently, and some states are less likely than others to find that an aide’s behavior is abusive. The GAO has recommended that CMS clarify its own definition of abuse so that states can “consistently and accurately” cite instances of abuse. Id. at 5.

136 See id. at 4. In addition to these registries, nursing homes may run criminal background checks on applicants through local and federal law enforcement agencies. However, the information in all three of these resources is often not entirely accurate and updated. See id. at 8.

137 See id. at 4.

138 See Polisky, supra note 22, at 385-86. On the other hand, according to CMS officials, intent is key to a finding of abuse, although that intent “can be formed in an instant.” Aronovitz, Shortcomings, supra note 125, at 5.

139 See Polisky, supra note 22, at 386.

140 See Aronovitz, Shortcomings, supra note 125, at 13.

141 See National Association of Medicare Fraud Controls Unit, http://www.namfcu.net/contacts/mfcu-contacts (last visited Sept 14, 2009). This website provides the contact information and links to the official MFCU websites of each of the 50 states. New York’s MFCU is run out of the Office of the Attorney General. See id.

142 See id.

143 See Aronovitz, Shortcomings, supra note 125, at 4. Once criminal charges are brought against a nursing home, MFCU conducts a criminal investigation. While part of the MFCU’s
ment that keeps an eye on the state’s nursing homes and makes these referrals.\textsuperscript{144} The Health Department has the task of ensuring that these homes live up to New York State regulations\textsuperscript{145} and of proposing sanctions for nursing homes with deficiencies to CMS.\textsuperscript{146}

One method used by the MFCU to investigate claims of elder abuse and neglect is through hidden surveillance cameras, like those used in the Medford nursing home.\textsuperscript{147} The MFCU first began the initiative to reveal institutional elder neglect in New York State through the use of hidden surveillance cameras in 2005 under Attorney General Elliot Spitzer.\textsuperscript{148} This initiative continues today under Attorney General Andrew Cuomo, with the specific purpose of gathering evidence to prosecute health care workers who mistreat their patients.\textsuperscript{149}

The frequency of elder neglect in healthcare facilities varies by state.\textsuperscript{150} This may be correlated with interstate inconsistencies in laws regarding civil and criminal liability for elder abuse and neglect.\textsuperscript{151} For instance, statewide laws and definitions of neglect vary greatly.\textsuperscript{152} However, all of the fifty state legislatures have passed some form of elder abuse prevention law.\textsuperscript{153} For example, California seemingly has some of

\textsuperscript{145} See Aronovitz, Shortcomings, supra note 125, at 13.
\textsuperscript{146} See Nursing Home Staffing, supra note 13, at 4.
\textsuperscript{147} N.Y. State Office of the Attorney Gen. & Medicaid Fraud Control Unit, Report to the Secretary, United States Department of Health and Human Services 8 (2005), http://www.oag.state.ny.us/media_center/2006/mar/mar31b_06.html (follow “2005 Report” hyperlink under “Attachments”).
\textsuperscript{148} See id.
\textsuperscript{149} See Long Island Investigation, supra note 2.
\textsuperscript{150} See Rudder et al., Failure of Survey & Complaint Systems, supra note 42, at 3.
\textsuperscript{151} Polisky, supra note 22, at 378.
\textsuperscript{152} Admin. on Aging, Dep’t of Health & Human Serv., What is Elder Abuse?, http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/EA_Prevention/whatIsEA.aspx (last visited Nov. 18, 2009); see also NYC Elder Abuse Research, supra note 12 (breaking elder abuse down into the four most common types, which are: physical abuse, emotional or psychological abuse, financial exploitation, and neglect or abandonment, and noting that these definitions vary by state).
\textsuperscript{153} NYC Elder Abuse Research, supra note 12. These elder abuse prevention laws include elder neglect prevention as well as define elder abuse as “an umbrella term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.” Admin. on Aging, Dep’t of Health & Human Serv., What is Elder Abuse?, http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/EA_Prevention/whatIsEA.aspx (last visited Nov. 18, 2009).
the most protective elder abuse prevention laws. California's Elder Abuse Act provides that “the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering” constitutes elder abuse. The Act provides for heightened remedies for injuries and damages in cases where they are caused by healthcare providers' “recklessness, oppression, fraud, or malice.” The remedies include attorney's fees and costs, “pain and suffering” damages, and punitive damages in certain circumstances. However, heightened remedies are not provided in cases of negligence where there is no evidence of recklessness. Yet, in spite of California's heightened remedies, a GAO study found that California's nursing homes have a shockingly high rate of sub-par conditions – almost one in three California homes have been written-up for “serious or potentially life-threatening care problems.” This study was prompted in 1993 by claims that 3,113 residents living in nursing homes died from malnutrition and dehydration resulting from poor care.

California's elder abuse and neglect laws are a step in the right direction, but they should be expanded to provide heightened remedies when there is not only evidence of recklessness, but also when there is evidence of patient neglect. Fear of heightened liability could provide a large incentive for nursing home owners and directors to better supervise their employees and ensure that they are not neglecting the residents. Unfortunately, since California's Elder Abuse Act is a statewide law, these heightened remedies only apply to California residents.

The New York legislature should consider drafting similar legislation addressing elder maltreatment where there is evidence of reckless behavior or neglect.

154 See generally Elder Abuse and Dependent Adult Civil Protection Act, Cal. Welf. & Inst. Code § 15610.07 (Deering 2008).
155 Id.
156 See id. § 15657.
157 See Baker, 971 P.2d at 988.
159 See Baker, 971 P.2d at 991.
160 See NYC Elder Abuse Research, supra note 12 (quoting a federal study conducted by the General Accounting Office).
161 Id.
162 See Oshiro, 2008 WL 2082140, at *8.
163 See Elder Abuse and Dependent Adult Civil Protection Act § 15610.07.
The Assembly Subcommittee on the Administration of Justice and legislative history indicate that the enactors of the California Elder Abuse Act intended to make the term "professional negligence" a separate, mutually exclusive type of negligence from "abuse" and "neglect." Professionals are not held to a heightened standard of care based on their skills and training under the Act. Causes of action for professional negligence against healthcare providers, such as nursing home employees, would be most effective if reforms were made so they could be brought under the Act like those for general abuse and neglect. Caregivers should also be held to a higher standard based on their degree of training and experience. New York State might see a reduction in elder neglect if statewide provisions were adopted that included these proposed heightened standards and the heightened remedies provided for in California for incidents of professional negligence towards the elderly.

Florida has also taken strides to try to ensure that its elderly residents are well cared for in the state’s nursing home facilities. Florida’s laws, such as the Nursing Home Residents’ Rights Act, at one point looked to protect nursing home residents through the enforcement of their rights through causes of action and remedies. The Act recognized that typical remedies resulting from a successful lawsuit may be of little value to nursing home residents because of their advanced age. In response to these concerns, the Act provided for attorney’s

164 See Baker, 971 P.2d at 990. In Baker, a California nursing home was sued on behalf of a deceased resident. The plaintiff alleged various causes of action, including reckless neglect under the Elder Abuse Act. There was evidence that the plaintiff’s parent had been left “lying in her own urine and feces for extended periods of time.” The plaintiff alleged that this neglect was the result, at least partly, of “rapid turnover of nursing staff, staffing shortages, and inadequate training of employees.” Id. at 988. The court explained that the legislative history to the Elder Abuse Act makes it clear that lawsuits for professional negligence against health care providers are to be decided by laws that specifically relate to professional negligence actions, rather than by §§ 15657 and 15657.2 of the Act. See id. at 988-90.

165 See id. at 991.

166 California limits the heightened remedies to only certain situations so that “frivolous lawsuits” will not be brought. See id. at 989.

167 U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTORS - ASSISTED LIVING: EXAMPLES OF STATE EFFORTS TO IMPROVE CONSUMER PROTECTIONS 7 (2004) (reporting that Florida has taken steps to help consumers choose the best assisted living centers for them by, for example, setting up a website where they can learn about assisted living facilities in their area and search for various desired services and price ranges).


169 See Romano, 861 So. 2d at 63.
fees on top of other remedies so that nursing home residents would have greater reason to enforce their rights. Without worrying about having to pay what are often hefty attorney’s fees, this award eliminated one deterrent standing in the way of elderly residents bringing lawsuits against their nursing homes. A fear of being forced to pay attorney’s fees to successful claimants may also push nursing home supervisors and directors to better supervise their staff.

Unfortunately, the provision providing for attorney’s fees has since been repealed in Florida. New York law, on the other hand, allows for an award of attorney’s fees at the judge’s discretion “if justice requires,” and is “based on the reasonable value of legal services rendered and payable by the defendant.” Since this award is only discretionary, it will not eliminate the financial deterrent that elders and their relatives often face when considering bringing actions against institutional health care providers. New York law does, however, award compensatory damages “sufficient to compensate” a patient for an injury resulting from, or the deprivation of a right or benefit by, a health care facility. The New York Public Health Law creates a private right of action for patients residing in residential healthcare facilities. Under this law, the minimum compensatory damages are twenty-five percent of the per-patient rate of payment per day. The law also awards punitive damages when the act is willful or reckless. Punitive damages should also be awarded in cases of neglect causing harm to residents.

Some states, including Georgia, Illinois, and Pennsylvania, prohibit the hiring of nursing home employees who have committed offenses outside of nursing homes. These crimes include kidnapping, murder, assault, battery, and forgery. Even with the increased hiring standards in certain states, there are still many problems in the background check

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170 See id.
171 See id.
172 See id. at 63 n.1.
173 N.Y. PUB. HEALTH LAW § 2801-d(6) (McKinney 2007).
174 See Romano, 861 So. 2d at 63. The court in Romano explained that in enacting The Nursing Home Resident’s Rights Act, the legislature recognized that often the enforcement of elder rights are not “financially valuable” and therefore the Act provides for attorney’s fees to make sure that elders are able to enforce their rights. See id. at 62-63.
175 N.Y. PUB. HEALTH LAW § 2801-d(2) (McKinney 2007).
176 See id.
177 See id.
178 See Aronovitz, Shortcomings, supra note 125, at 3.
179 See id.
system – there are gaps in the registries, the registries often do not include accurate and up-to-date information, and background checks are only made statewide.\(^{180}\) Therefore, even in the states with the most thorough background checks, the standards are still too low; potential hires are falling through the cracks and applicants from outside states are not being screened.\(^{181}\) Furthermore, in hiring caregivers for some of the most vulnerable members of our society, nursing homes should strive to hire only those with exceptional qualifications, rather than merely looking to eliminate those with criminal convictions.

There are also international efforts to make the United States and the rest of the world more aware of elder neglect, abuse, and exploitation.\(^{182}\) For example, World Elder Abuse Awareness Day (WEAAD) takes place each year on June 15.\(^{183}\) It first began in 2006 at the United Nations in New York City.\(^{184}\) Its goal is to bring awareness to all Americans of the abuse, neglect, and exploitation that the elderly population suffers\(^{185}\) and to provide information on the prevention of such abuses.\(^{186}\) Each year, the day includes many organized programs to help raise awareness, such as the development of future programs and press conferences.\(^{187}\) It is hoped that such international efforts will make people aware of the prevalence of elder neglect and ways in which it can be prevented.

IV. PROPOSED CHANGES TO NEW YORK STATE ELDER NEGLECT LAWS

To combat elder neglect, accurate research identifying its specific causes needs to be compiled\(^{188}\) and then needs to be translated into practice.\(^{189}\) To help facilitate this research process, more victims of neg-

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\(^{180}\) See id. at 8-9.

\(^{181}\) See id.


\(^{183}\) Id.

\(^{184}\) See id.


\(^{186}\) See International Network for the Prevention of Elder Abuse, supra note 183 (follow "Read all about World Elder Abuse Awareness Day" hyperlink).

\(^{187}\) See id.

\(^{188}\) See RUDDER & SHINEMAN, NURSING HOME OVERSIGHT, supra note 41, at 2.

\(^{189}\) See TRANSLATING RESEARCH INTO PRACTICE, supra note 6, at 34.
lect need encouragement to report such incidents.\textsuperscript{190} These reports would help experts properly assess and identify problem areas within each facility.\textsuperscript{191} According to the National Academy of Elder Law Attorneys (NAELA) Survey on Elder Issues, the majority of elder abuse cases actually go unreported.\textsuperscript{192} Without the reporting of incidents, people may falsely believe that there are not as many instances of neglect as there are in actuality.\textsuperscript{193}

Furthermore, we as a society need to understand why residents and their families frequently fail to file these complaints, and why there are delayed investigations of those that are filed.\textsuperscript{194} Such delays are likely disincentives to the filing of reports; if reported incidents are not investigated in a timely manner then there is little reason, when balanced against the fear of possible retaliation, for residents and their families to file them in the first place.\textsuperscript{195} In order to encourage residents and their families to come forward and file complaints, we must find ways to make them feel secure in knowing there will not be retaliation by their caregivers. While New York Public Health Law § 2803-d prohibits retaliation against people who file reports of neglect,\textsuperscript{196} such retaliation still occurs.\textsuperscript{197}

\begin{footnotesize}
\textsuperscript{190} See id.
\textsuperscript{191} See id.
\textsuperscript{192} See Nat'l Acad. of Elder Law Attorneys, Media: Eye on Elder Issues, http://www.naela.org/Media_EyeOnElders.aspx (last visited Sept. 16, 2009); Breaux & Hatch, supra note 81, at 220-21. Recent research has estimated that as many as 84% of elder abuse cases go unreported. See id. at 209.
\textsuperscript{193} See RUDDER & SHINEMAN, NURSING HOME OVERSIGHT, supra note 41, at 6.
\textsuperscript{194} See id.
\textsuperscript{195} There are "powerful incentives ... for victims, their families, and witnesses to keep silent or delay the reporting of abuse allegations." Aronovitz, Shortcomings, supra note 125, at 5 (explaining that this is the reason why it is hard to measure the extent of elder abuse in nursing homes); see also UNDERSTANDING ELDER MALTREATMENT FACT SHEET, supra note 11. The fear of residents' family members' retaliatory acts is not baseless. In one New York nursing home, there have been instances where "whistleblowers" (those alleging abuse of their family members) have been ousted from their family member's care plan. Such retaliatory measures have even gone as far as removing a "whistleblower" from his or her position as health care proxy and refusing to admit another resident unless the guardian, who had previously voiced criticism against a health network providing "medical services" for the home, was removed. Further reports of instances of abuse and neglect in this home were not made because of a fear of further retaliation. See Polisky, supra note 22, at 388.
\textsuperscript{196} N.Y. PUB. HEALTH LAW § 2803-d (McKinney 2004).
\textsuperscript{197} See Criminalizing Elder Abuse, supra note 22.
\end{footnotesize}
Another problem with the current laws is that no uniformity exists amongst the states in penalizing elder abuse and neglect. Furthermore, the laws are not comprehensive, and many statewide definitions of abuse are "ambiguous," creating confusion regarding what actually constitutes abuse and neglect on a state-by-state basis. For example, New York Public Health Law § 2803-d requires people who have "reasonable cause to believe" that somebody is being neglected in a health care facility to report such occurrences. Subdivision five of this law provides that licensed professionals who commit acts of neglect are guilty of "unprofessional conduct in the practice of [their] profession." However, this provision is not all-inclusive; it does not mention unlicensed professionals working in healthcare facilities, such as aides. Aides must be explicitly mentioned in the New York law, since they most frequently care for the elderly and have often been found neglecting their patients. Subdivision seven does, however, provide for somewhat of a catchall provision, imposing liability on "any person" committing an act of neglect. In spite of this general provision, the law should be revised to add a provision specifically prohibiting aides from neglecting their patients.

A person found violating this New York Public Health Law is currently subject to certain penalties, including a civil fine of up to two thousand dollars for a first-time violation and up to five thousand dollars for repeated violations within one year and for those who pose "a serious threat to the health and safety of an individual." There is also a fine of up to ten thousand dollars for violations that actually cause such harm. However, these financial penalties are not enough of a deterrent, since neglect is still extremely prevalent today. Even the

198 See id. at 389.
199 Id. at 392.
200 N.Y. PUB. HEALTH § 2803-d (McKinney 2004).
201 Id.
202 See id.
203 See supra notes 22-29 and accompanying text.
204 N.Y. PUB. HEALTH LAW § 2803-d.
205 N.Y. PUB. HEALTH LAW § 12 (McKinney 2008).
206 Id.
207 See supra notes 2-3 and accompanying text. The New York State Department of Health compares how the New York State nursing homes compare to national averages in areas that are key to the quality of care residents receive. In a few areas, they performed horrifically. For example, New York State homes only received one out of five stars for avoiding pressure sores. See N.Y. State Dep't of Health, New York State Nursing Homes National Ranking, http://nursinghomes.nyhealth.gov/ny2nat.php (last visited Sept. 16, 2009). According to the Depart-
highest penalty of ten thousand dollars seems like a small repercussion for those who put innocent and often helpless people’s lives in danger. While ten thousand dollars may be financially crippling, it does not compare to the physical suffering that is often caused by elder neglect. A financial penalty is not a severe enough punishment when there is actual harm caused — the law should be changed to include possible jail time for these violations in the most egregious circumstances.

Another New York law that should be amended and improved is New York Public Health Law § 2803-c, which requires nursing homes and other similar facilities to “adopt and make public a statement of the rights and responsibilities of the patients who are receiving care in such facilities.” The New York legislature should further extend this requirement. Legislation should be drafted that similarly mandates that a statement of caregivers’ responsibilities be posted in every nursing home floor hallway. This posting should include a list of possible penalties for the violation of its provisions. Each nursing home employee should receive a copy of his or her responsibilities on the first day of the job. They should also be required to sign a form acknowledging that they have read and understand their responsibilities and agree to comply. The consequences for a violation should also be included. This type of a public statement would hopefully serve as a constant reminder to nursing home employees about their responsibilities, the standard of care they are expected to provide, and the consequences to them if they do not meet the state-imposed standard of care. Furthermore, upon starting a new position, caregivers should be taught their responsibilities through orientation and training sessions. There should also be continuing mandatory caregiver follow-up training, regulated by each state, similar to the state-by-state Continuing Legal Education (CLE) requirements in place.

208 See N.Y. State Dep’t of Health, Required Postings, http://www.health.state.ny.us/facilities/nursing/rights/required_postings.htm (last visited Sept. 16, 2009) (listing the information that must be posted in nursing home facilities in an easily viewable area to residents and the public).
Finally, New York State law makes it a felony to “[e]ndanger[ ] the welfare of a vulnerable elderly person in the second degree.”\textsuperscript{210} This law, however, needs to be more stringently enforced. A person is guilty of this felony when acting as a “caregiver for a vulnerable elderly person he or she recklessly causes physical injury to such person.”\textsuperscript{211} Nursing home employees tending to the elderly fall within the New York Penal Law’s definition of caregivers.\textsuperscript{212} Caregivers are defined under the New York Penal Law as including “a person who . . . assumes responsibility for the care of a vulnerable elderly person . . . or receives monetary . . . consideration for providing care for a vulnerable elderly person.”\textsuperscript{213} A caregiver acts recklessly towards an elderly person when,

\[\text{[H]}\text{e is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation . . . .}\textsuperscript{214}\]

Therefore, according to the above laws, caregivers working in nursing homes commit a felony when they disregard the well-being of the residents they are paid and instructed to look after. While such laws are in place, their effectiveness is questionable, as is evidenced through the high number of elder abuse and neglect convictions in New York State caught on surveillance cameras alone.\textsuperscript{215} In spite of the New York laws attempting to protect the elderly, the state’s nursing homes have many deficiencies compared to homes in other states around the country.\textsuperscript{216}

One reason for the ineffective legislation may relate back to the lack of accurate research on inappropriate and sub-par elder care practices and facilities.\textsuperscript{217} With little research on institutional elder neglect as compared to other types of abuse and neglect, it is no wonder why the issue receives less attention from the federal government.

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\textsuperscript{210} N.Y. Penal Law § 260.32(2) (McKinney 2009).
\textsuperscript{211} Id.
\textsuperscript{212} See N.Y. Penal Law § 260.30(1) (McKinney 2009).
\textsuperscript{213} Id.
\textsuperscript{214} N.Y. Penal Law § 15.05(3) (McKinney 2009).
\textsuperscript{215} See Long Island Investigation, \textit{supra} note 2.
\textsuperscript{216} See Ruddr & Shinem, \textit{Nursing Home Oversight, supra} note 41, at 6. They are ranked especially low on staffing (understaffing and high employee turnover), and on identifying care-related problems. \textit{See id.}
\textsuperscript{217} Polisky, \textit{supra} note 22, at 381.
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Conclusion

With dismal ratings for many nursing homes in New York State, it is time for both the federal government and the New York legislature to implement new laws and programs that will help improve the quality of care residents living in nursing homes and similar healthcare facilities receive. The first step is identifying the real extent of the problem and its causes. The Department of Health needs to hone in on exactly where the deficiencies lie and create a thorough and comprehensive report. This process needs to begin with a more accurate survey process, rather than with mere inquiries to administrators whose jobs are to cast their healthcare facilities in the best possible light.

New York should also focus on increasing and improving the number and quality of nursing home employees, particularly nurses and aides, by setting stricter regulations and hiring practices, setting harsher penalties for neglect, and implementing mandatory training workshops throughout the year. In working to improve its laws, New York should also look to other states with fewer instances of neglect and better nursing home ratings as a guide. New York legislation should then be drafted and implemented to incorporate these successful healthcare laws and practices. While New York needs to address the problem on the statewide level, the federal government also needs to provide greater oversight, draft comprehensive legislation that will provide more resources to the states, and implement a new nursing home ratings system that will set a higher bar for the quality of care for the country as a whole.