

You Cannot Protect Elders Unless You Protect the Institutions That Care for Them: How Streamlining the Definition of Elder Abuse Will Positively Impact the Long-Term Care Industry

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**YOU CANNOT PROTECT ELDERS UNLESS YOU
PROTECT THE INSTITUTIONS THAT CARE FOR
THEM: HOW STREAMLINING THE DEFINITION OF
ELDER ABUSE WILL POSITIVELY IMPACT
THE LONG-TERM CARE INDUSTRY**

INTRODUCTION

The elderly population is vulnerable¹—so too are the health care facilities that care for them.² Nursing homes, most notably skilled nursing facilities, are quickly becoming one of the most important industries in the United States.³ As baby boomers approach old age, the need for nursing homes will dramatically increase.⁴ Consequently, it is crucial that nursing facilities provide quality care to the aging population, which is comprised of grandfathers, parents, neighbors, and loved ones.⁵ Unfortunately, nursing homes currently have a negative

1. “[T]he elderly are especially vulnerable because ‘abusers may assume that frail victims will not survive long enough to follow through on legal interventions or will not make convincing witnesses.’” Janine Robben, *Keeping an Eye Out for Elders*, OR. ST. B. BULL., Apr. 2009, at 19, 22 (quoting Mohammad Bader, Program Manager, Multnomah County Adult Protective Services).

2. See Allyson Marcus, *Liability Costs on the Rise for Long Term Care Facilities, Finds AHCA and Aon*, AM. HEALTH CARE ASS’N (Nov. 21, 2013), http://www.ahcancal.org/News/news_releases/Pages/Liability-costs-on-the-rise-for-long-term-care-facilities,-finds-AHCA-and-Aon.aspx (indicating that liability costs and claims for long-term care providers are increasing, and certain states have more vulnerable legal climates).

3. See generally Robyn Stone, *Long-Term Care: Coming of Age in the 21st Century*, WIS. FAM. IMPACT SEMINARS, Feb. 1999, at 1, 1, http://www.familyimpactseminars.org/s_wifis12c01.pdf. The terms “nursing home” and “skilled nursing facility” are used interchangeably but do have technical differences dealing with “which entity regulates and certifies the facility.” Marlo Sollitto, *What’s the Difference Between Skilled Nursing Facilities and a Nursing Home?*, AGINGCARE.COM, <https://www.agingcare.com/Articles/difference-skilled-nursing-and-nursing-home-153035.htm> (last visited Jan. 31, 2016) (quoting Jane Shukitis, Senior Vice President, Aging and Community Services, Unity Health System). For example, skilled nursing facilities are “regulated by the Department of Health and must meet strict criteria.” *Id.* Some of the criteria include: registered nurses, medical directors, and transfer agreements with hospitals. *Id.* Nursing homes may have some of the same health professionals, but nursing homes “are not covered by Medicare and Medicaid because they are not certified and not regulated by the national government.” *Id.* Throughout this Comment, “nursing home” and “skilled nursing facility” may be used interchangeably.

4. “The demand for long-term care is expected to skyrocket as the baby boomers age.” Stone, *supra* note 3, at 1.

5. See Elizabeth Pope, *9 Strategies To Help a Parent Who Refuses Care*, CARE.COM, <https://www.care.com/a/9-strategies-to-help-a-parent-who-refuses-care-1106221448> (last visited Jan. 31, 2016) (describing the challenges of convincing elderly family members to accept necessary care).

reputation for providing subpar care to residents, and they are often criticized as a vehicle for elder abuse.⁶

Residents and their family members often rely on litigation to hold facilities accountable for their failures.⁷ This litigation stems from claims of institutional negligence, medical malpractice, wrongful death, and elder abuse.⁸ Moreover, nursing home litigation has become prevalent because nursing facilities have many risk factors and are prone to accidents due to the nature of caring for ailing elders.⁹ However, nursing home litigation has been a means for attorneys to pocket payouts from large settlements of nursing home abuse and negligence claims.¹⁰ Every industry should be held accountable for its failures; however, duplicitous and frivolous litigation may actually hurt the nursing home industry rather than promote quality care.¹¹

Millions of dollars are spent on litigation each year, which decreases a facility's ability to provide quality care.¹² Notably this money comes

6. "Despite extensive regulatory efforts, nursing homes perpetually promote a cycle of abuse and subsequently endanger a significant portion of the population." Linda K. Chen, Comment, *Eradicating Elder Abuse in California Nursing Homes*, 52 SANTA CLARA L. REV. 213, 215 (2012).

7. "Consumer advocates and the plaintiffs' bar have long argued that lawsuits are essential to ensuring high-quality care." David G. Stevenson & David M. Studdert, *The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys*, HEALTH AFFAIRS, Mar./Apr. 2003, at 219, 225.

8. For example, a plaintiffs' attorney's website states that "Idaho has several statutes to protect nursing home residents from abuse, including the Adult Abuse, Neglect and Exploitation Act and Adult Protective Services. . . . [T]here is more than one legal claim that could be brought against the nursing home," including: negligence, medical malpractice, and wrongful death." *When Nursing Home Abuse Occurs, It's Up to You To Stand Up for Your Loved One*, MORTON L. OFFICES, <http://www.mortonlawyers.com/library/legal-claims-you-can-bring-in-nursing-home-abuse-cases.cfm> (last visited Feb. 4, 2016).

9. "Nursing Homes overall are a pretty hazardous risk to begin with . . ." Denise Johnson, *Nursing Home Liability Claims Require Specialized Handling*, CLAIMS J. (Sept. 12, 2014), <http://www.claimsjournal.com/news/national/2014/09/12/254615.htm> (quoting Rob Jurgel, Underwriting President, SCI Underwriting Management).

10. "Major nursing-home operators and industry groups say many of the lawsuits line attorneys' pockets while doing little to improve the quality of care." Jennifer Smith, *Lawsuits Rattle Nursing-Home Chains*, WALL ST. J., Oct. 3, 2014, <http://online.wsj.com/articles/lawsuits-rattle-nursing-home-chains-1412368400>.

11. *Id.* "It is one thing to seek redress when a facility has been negligent. Every industry can and should be held accountable for its shortcomings. However, it is another thing altogether to take information intended to benefit consumers and exploit it simply as a means of trolling for clients." Doug Alexander, *Predatory Lawsuits Hurt Nursing-Home Patients*, KENTUCKY.COM (July 2, 2012), http://www.kentucky.com/2012/07/02/2245596_doug-alexander-predatory-lawsuits.html?rh=1.

12. Press Release, PHCA/CALM Chair Advocates for Lawsuit Abuse Reform at Press Conference 2 (Sept. 10, 2012) (on file with the Pennsylvania Health Care Association) (examining how much Pennsylvania pays in settlement costs). "These needless litigation costs divert already limited and much-needed dollars away from care." *Id.* at 1 (quoting Diane Johnson, Regional Director of Operations, HCR Manor Care).

from facilities already experiencing the effects of federal budget cuts¹³—notwithstanding the fact that no correlation has been found to exist between a facility's performance and lawsuits.¹⁴ A study reported in the *New England Journal of Medicine* showed that “[t]he best-performing nursing homes are sued only marginally less than the worst-performing ones.”¹⁵ Arguably the majority of cases are targeting the industry as a whole rather than advocating for individuals on a case-by-case basis.

Further, litigation may be more common in certain geographic areas due to the fact that each state has a different definition of “elder abuse.”¹⁶ The states' varying definitions either invite plaintiffs' attorneys to sue for nursing home abuse or discourage them from doing so.¹⁷ Some states have broad definitions, inducing attorneys to flock to those particular states and pursue elder abuse cases in nursing homes.¹⁸ By contrast, other states have narrow definitions that are less attractive to attorneys.¹⁹ A balance must be struck so that there are enough protections in place for elders while also providing nursing facilities with proper notice of their liability.

To resolve the disparities among state-enacted elder abuse definitions, and with the hope of reducing unnecessary and duplicitous nursing home litigation, this Comment advocates for the federal government to create a uniform definition of elder abuse that states would be incentivized to adopt. If adopted, the uniform definition would prevent attorneys from targeting certain jurisdictions in which regulations are less comprehensive. A uniform definition of elder abuse will help promote nursing home businesses during a time when they are in high demand while also holding these establishments accountable for abusive actions. Part II discusses the background of: (1) the growing need for long-term care; (2) the challenges facing the nursing home industry; (3) previous and current quality driven legislation; (4) nursing home litigation trends; and (5) how statutory definitions of elder abuse impact litigation in Arizona, Illinois, Kentucky,

13. Smith, *supra* note 10.

14. David M. Studdert et al., *Relationship Between Quality of Care and Negligence Litigation in Nursing Homes*, 364 N. ENG. J. MED. 1243, 1247 (2011).

15. *Id.* at 1247–48.

16. See NAT'L CTR. FOR STATE COURTS, PROSECUTING ELDER ABUSE CASES: BASIC TOOLS AND STRATEGIES 32 (2012), <http://www.eldersandcourts.org/Elder-Abuse/~media/Microsites/Files/cec/Prosecution%20Guide.ashx>.

17. See *id.*

18. See, e.g., ARIZ. REV. STAT. ANN. § 46-451 (2014).

19. See, e.g., 320 ILL. COMP. STAT. 20/2 (2014); 35 PA. STAT. AND CONS. STAT. ANN. § 10225.103 (West 2012).

and Pennsylvania.²⁰ Part III analyzes nursing home litigation in light of the varying definitions of elder abuse and illustrates what a model elder abuse statute should look like.²¹ Part IV discusses both the positive and negative impacts that the uniform definition would have on the legal community.²²

II. BACKGROUND

A. Long-Term Care Is Needed Now More than Ever

It is estimated that by the year 2030, seventy-two million people, almost 20% of the U.S. population, will be individuals over age sixty-five.²³ Between 1980–2010, the number of individuals over age ninety almost tripled to approximately 1.9 million,²⁴ and this number is expected to quadruple by 2050.²⁵ It is a generally accepted premise that as life expectancy increases, the need for health services, specifically efficient and well-regulated long-term care facilities,²⁶ will also surge.²⁷

Long-term care facilities typically include nursing homes, assisted living facilities, and continuing care retirement communities (CCRCs).²⁸ Nursing homes provide the “most comprehensive range of services” with twenty-four hour supervision and medical care.²⁹ Like nursing homes, assisted living facilities provide everyday assistance to elders, but they do not provide actual nursing care.³⁰ Individuals living in these facilities have difficulty completing everyday tasks, such as bathing, dressing, and eating.³¹ CCRCs provide several levels of care on one campus, including independent living, assisted living,

20. See *infra* notes 23–176 and accompanying text.

21. See *infra* notes 177–291 and accompanying text.

22. See *infra* notes 293–311 and accompanying text.

23. Debra H. Kroll, *To Care or Not To Care: The Ultimate Decision for Adult Caregivers in a Rapidly Aging Society*, 21 TEMP. POL. & C.R. L. REV. 403, 403 (2012).

24. *Id.* at 404.

25. *Id.*

26. *Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets: Testimony Before the S. Spec. Comm. on Aging*, 107th Cong. 1–2 (2002) [hereinafter *Long-Term Care Testimony*] (statement of David M. Walker, U.S. Comptroller General).

27. Kroll, *supra* note 23, at 404.

28. *Can You Receive Care?*, LONGTERMCARE.GOV, <http://longtermcare.gov/the-basics/where-can-you-receive-care/> (last visited Nov. 23, 2015).

29. *Id.*

30. *Assisted Living*, ELDERCARE LOCATOR (Apr. 13, 2012), http://www.eldercare.gov/eldercare.net/public/resources/factsheets/assisted_living.asp.

31. *Long-Term Care Testimony*, *supra* note 26, at 3 (statement of David M. Walker, U.S. Comptroller General).

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and nursing home care.³² CCRCs allow residents to stay in one place and move to new levels of care on an as needed basis.³³ These facilities are designed to provide more intensive care as residents' conditions worsen.³⁴

Long-term care can be financially burdensome.³⁵ Although expenses vary, one year in a nursing home could cost more than \$80,000.³⁶ Residents normally begin their stays at nursing homes by paying out-of-pocket from their own personal assets,³⁷ and family members often contribute or assist with nursing home costs.³⁸ Some residents also purchase long-term care insurance plans that may cover nursing home care;³⁹ however, only approximately 10% of seniors actually have these insurance plans.⁴⁰ Once those resources run out, the resident may qualify for Medicaid,⁴¹ which is a joint program offered by the state and federal governments to provide medical costs for low-income individuals and people with few resources.⁴² Although individuals often mistakenly believe that the Medicare program, which covers some medical costs for individuals over sixty-five years of age,

32. JACQUELYN SANDERS, U.S. DEP'T OF HEALTH & HUMAN SERVS., CONTINUING CARE RETIREMENT COMMUNITIES: A BACKGROUND AND SUMMARY OF CURRENT ISSUES 1, 4 (1997), <http://aspe.hhs.gov/daltcp/reports/ccrcrpt.pdf>.

33. *Id.* at 1.

34. *Id.*

35. Blake Ellis, *Nursing Home Costs Top \$80,000 a Year*, CNN MONEY (Apr. 9, 2013, 3:21 PM), <http://money.cnn.com/2013/04/09/retirement/nursing-home-costs/>.

36. *Id.*

37. *How Can I Pay for Nursing Home Care?*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/paying-for-nursing-home-care.html> (last visited Aug. 14, 2015).

38. "The cost of senior care can stretch family budgets to the breaking point . . ." *Medicare vs Medicaid*, PLACE FOR MOM, <http://www.aplaceformom.com/senior-care-resources/articles/senior-care-costs> (last updated Mar. 18, 2014).

39. *How Can I Pay for Nursing Home Care?*, *supra* note 37.

40. Michelle Andrews, *Few Seniors Have Long-Term Care Insurance*, KAISER HEALTH NEWS, (Dec. 14, 2010), <http://www.kaiserhealthnews.org/features/insuring-your-health/michelle-andrews-on-long-term-care-policies.aspx>.

41. Medicare is a federally run program that provides insurance for those: (1) sixty-five and over; (2) under sixty-five with certain disabilities; and (3) individuals of any age who have end-stage renal disease (permanent kidney failure). U.S. DEP'T OF HEALTH & HUMAN SERVS., WHAT'S MEDICARE? 1 (rev. June 2015), <https://www.medicare.gov/Pubs/pdf/11306.pdf>. Medicare is funded through payroll taxes, Medicare Part A premiums, and income taxes on Social Security benefits. *How Is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html> (last visited Jan. 31, 2016). The state and federal governments jointly run Medicaid. *Medicaid*, MEDICARE.GOV, <https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html> (last visited Jan. 31, 2016). The program "helps with medical costs for some people with limited income and resources." *Id.* Medicaid also covers additional benefits that Medicare does not cover, including "nursing home care and personal care services." *Id.*

42. *Id.*

will cover long-term care expenses, it does not.⁴³ Medicare only covers short-term nursing home care (e.g., if a person is recovering from hip surgery and needs to rehabilitate).⁴⁴ Medicare will completely cover the first twenty days of a resident's stay, and for the next twenty to 100 days, Medicare will cover all costs aside from the copayment.⁴⁵ After 100 days, Medicare ceases to cover any expenses.⁴⁶

As the U.S. population ages, many individuals find themselves unable to afford nursing home care, which is why many elderly adults must rely on home care by unpaid family members and friends.⁴⁷ However, due to increased life expectancies, the elderly may not have spouses, siblings, adult children, or friends to help care for them.⁴⁸ "By 2020, the number of elderly who will be living alone with no living children or siblings is estimated to reach 1.2 million, almost twice the number without family support in 1990."⁴⁹ As a result, more individuals will be forced to resort to nursing homes and other long-term care facilities.⁵⁰ It is anticipated that the number of elderly individuals using nursing homes and other long-term care facilities will "increase from 15 million in 2000 to 27 million in 2050."⁵¹

B. Challenges Facing Nursing Facilities

The influx of the elderly population has brought several issues to the forefront for long-term care facilities. These issues include: (1) reporting elder abuse in household and nursing home settings; (2) understaffing, high employee turnover rates, and underqualification of employees; (3) upturn in medically complex patients; and (4) increasing administrative burdens of care facilities.

At the core of all issues facing nursing facilities is the concern of protecting elders from any type of harm or abuse, which has become a serious national epidemic.⁵² Adult Protective Services (APS), a state-

43. *Id.*

44. U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE COVERAGE OF SKILLED NURSING FACILITY CARE 8, 18 (rev. 2015), <http://www.medicare.gov/pubs/pdf/10153.pdf>.

45. *Id.* at 7 tbl.

46. *Id.*

47. *Long-Term Care Testimony*, *supra* note 26, at 3, 12 (statement of David M. Walker, U.S. Comptroller General).

48. *See id.* at 12.

49. *Id.*

50. *See id.*

51. L. Harris-Kojetin et al., *Long-Term Care Services in the United States: 2013 Overview*, VITAL & HEALTH STAT., Dec. 2013, at 1, 3.

52. Priscilla Vargas Wrosch, *What More Can Congress Do About the Elder Abuse Epidemic? A Proposal for National Movement*, 23 TEMP. POL. & C.R. L. REV. 1, 43 (2013).

run organization that advocates for elders and works to prevent abuse, has reported a dramatic increase in elder abuse throughout the United States.⁵³ Elder abuse is a broad term that encompasses claims of physical, sexual, psychological, and financial abuse, as well as neglect and domestic violence.⁵⁴ In the United States, hundreds of thousands of elderly individuals are abused or neglected each year.⁵⁵ A projected “[10%] of elderly people suffer from abuse at least once a year”; however, the actual number is probably much higher because many victims do not report abuse.⁵⁶

Perhaps, surprisingly, trusted family members or close friends are the ones who most often commit elder abuse.⁵⁷ Nursing homes also contribute to these numbers due, in part, to quality issues.⁵⁸ Two thousand nursing home residents were interviewed for a study conducted in 2000, and 44% of those interviewees claimed that “they had been abused, and 95% said they had been neglected or seen another resident neglected.”⁵⁹

Increased skepticism of the care provided in these facilities is often attributed to understaffing, high turnover rates, and under-qualified employees.⁶⁰ Some states, including New York, do not have a mandatory minimum number of staff required at their care facilities, which often results in understaffing issues.⁶¹ Understaffing problems may lead to overworked employees who are forced to perform tasks that they are not necessarily qualified to do.⁶² For example, a nursing assistant may be forced to give a patient medication that should have been administered by a nurse or doctor.⁶³ There is also frequent turn-

53. *Statistics/Data*, NAT'L CTR. ON ELDER ABUSE, <http://www.ncea.aoa.gov/Library/Data/> (last visited Aug. 14, 2015).

54. *Elder Abuse Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/features/elderabuse/>.

55. *Id.*

56. David Heitz, *U.S. Official: Elder Abuse Is 'Broad and Widespread'*, HEALTHLINE (Jan. 27, 2014), <http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714#2>.

57. *Statistics/Data*, *supra* note 53.

58. *Id.*

59. *Id.* (citing K. BROYLES, NAT'L CITIZENS COAL. FOR NURSING HOME REFORM, ATLANTA LEGAL AID SOC'Y, *THE SILENCED VOICE SPEAKS OUT: A STUDY OF ABUSE AND NEGLECT OF NURSING HOME RESIDENTS* (2002)).

60. Amanda Bassen, Note, *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*, 8 CARDOZO PUB. L. POL'Y & ETHICS J. 179, 183–84 (2009); *Nursing Home Understaffing*, NURSING HOME ABUSE GUIDE, <http://nursinghomeabuseguide.com/resources/types-of-nursing-home-employees/understaffing/> (last visited Aug. 14, 2015).

61. Bassen, *supra* note 60, at 183–84.

62. *Id.* at 184.

63. *Id.*

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over in the industry because nursing assistants and aides are paid low salaries for an intense workload.⁶⁴ According to the U.S. Department of Labor, in 2014, nursing assistants' median pay was \$12.06 per hour with an average annual salary of \$25,090.⁶⁵ This can lead to a constant influx of new assistants at varying levels of experience.⁶⁶

The dynamics of nursing homes are also changing because facilities are accepting more medically complex patients.⁶⁷ Today, many individuals are going to nursing homes to rehabilitate not "to die" as was once the reputation.⁶⁸ The complexity of illnesses and the types of patients that nursing homes now receive require new skill sets.⁶⁹ "In the past, some [skilled nursing facilities (SNFs)] have opted not to go the high-acuity care route, for various reasons. But with more high-acuity patients entering the long-term care environment than ever before, this new reality is causing SNF administrators to take a closer look at what's involved"⁷⁰ When referring to nursing home providers who accept high-acuity patients, Lou Ann Soika, Senior Vice President at Genesis Rehab Services, stated: "I don't think you have a choice anymore."⁷¹ The nursing home industry is struggling to keep pace with these changes.⁷²

Additionally, nursing homes have increasingly large administrative burdens, which may be taking time away from patient-centered care.⁷³ The health care industry is one of the most heavily regulated industries in the United States.⁷⁴ Some fear that the health care industry is "more interested in advanced technology, federal regulation and personal data collection, than in doctor's care and life-saving treatment of

64. *Nursing Home Understaffing*, *supra* note 60.

65. *Nursing Assistants and Orderlies*, BUREAU LAB. STAT. (Dec. 17, 2015), <http://www.bls.gov/ooh/healthcare/nursing-assistants.htm>.

66. *See id.*

67. John Andrews, *Rehab: The New Math of LTC*, MCKNIGHTS (Apr. 1, 2011), <http://www.mcknights.com/rehab-the-new-math-of-ltc/article/199773/> (quoting Lou Ann Soika, Senior Vice President, Genesis Rehab Services).

68. "Patients were once called residents. They came and stayed for years. But now the average stay is a few weeks or a few months. . . . The goal for these patients is to get them home or to an assisted living facility." Joanne Kaldy, *A Look at New LTC Physician Models*, PROVIDER (Aug. 2011), <http://www.providermagazine.com/archives/archives-2011/Pages/0811/A-Look-At-New-LTC-Physician-Models.aspx> (quoting James Avery, Chief Medical Officer, Golden Living).

69. Andrews, *supra* note 67.

70. *Id.*

71. *Id.*

72. *Id.*

73. AM. HOSP. ASS'N & PRICEWATERHOUSECOOPERS, PATIENTS OR PAPERWORK?: THE REGULATORY BURDEN FACING AMERICA'S HOSPITALS (2001).

74. "As a result of interference at the federal and state levels, health care is one of America's most heavily regulated industries." *An Unhealthy Burden*, ECONOMIST, June 28, 2007, <http://www.economist.com/node/9407716> (citation omitted).

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patients.”⁷⁵ One example of a federal regulation is the minimum data set (MDS), which is an assessment tool used when a patient is admitted to a SNF.⁷⁶ MDS requires quarterly and annual updates in addition to updates with regard to condition change.⁷⁷ It measures physical, psychological, and psychosocial capabilities of residents while also collecting information on demographics, preferences, and sources of payment.⁷⁸ Although MDS is an important tool for assessing each resident’s capabilities and gathering information for statistical data, its difficult implementation is burdensome.⁷⁹ However, with periodic updates to MDS, the Centers for Medicaid and Medicare Services (CMS) has tried to take steps to reduce some of these burdens.⁸⁰ Each facility must hire specific MDS nurses to maintain this regulation; moreover, these nurses must keep up with time intensive training.⁸¹ “Too often, these rules are implemented with no consideration for increased paperwork.”⁸² PricewaterhouseCoopers, a firm that provides industry-specific consulting services for clients, did a survey of health systems and found that thirty minutes of paperwork is neces-

75. Louis Goodman & Tim Norbeck, Opinion, *Healthcare Is Turning into an Industry Focused on Compliance, Regulation Rather than Patient Care*, FORBES (Nov. 5, 2013, 8:52 AM), <http://www.forbes.com/sites/physiciansfoundation/2013/11/05/healthcare-is-turing-into-an-industry-focused-on-compliance-regulation-rather-than-patient-care/>.

76. AM. HOSP. ASS’N & PRICEWATERHOUSECOOPERS, *supra* note 73, at 5.

77. “OBRA ‘87 mandated assessment of residents using the MDS within 14 days of admission, and thereafter at least quarterly, annually, and with a significant change in status as defined in the regulation.” Rena R. Shephard, *MDS 3.0 Coding for OBRA and PPS*, AANAC (June 2013) (on file with author).

78. Shubing Cai et al., *Validation of the Minimum Data Set in Identifying Hospitalization Events and Payment Source*, 12 JAMDA 38, 38–43 (2011); *Long Term Care Minimum Data Set (MDS)*, CMS.GOV, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/LongTermCareMinimumDataSetMDS.html> (last modified Feb. 27, 2012, 5:27 PM).

79. “Nearly 18 months after implementation of the minimum data set (MDS) 3.0, changes and clarifications will be made to the assessment tool in an effort to ease concerns about the burden it has placed on providers and residents.” Meg LaPorte, *MDS 3.0 Changes Aimed at Easing Provider Burdens*, PROVIDER (Mar. 9, 2012), <http://www.providermagazine.com/news/Pages/MDS-30-Changes-Aimed-At-Easing-Provider-Burdens.aspx>.

80. The updates include transitions, such as the transition from MDS 2.0 to 3.0, and subsequent modifications to MDS 3.0. *Id.* (“Among the modifications are new definitions for planned and unplanned discharges, changes to Section Q that reduce the frequency of questions about a resident’s preference to return to the community, and less frequent edits to the resident assessment instrument (RAI).”).

81. “Even if the MDS 3.0 is a quicker assessment process than the MDS 2.0, SNFs will undergo many time-consuming changes as the new system is implemented.” *Save Valuable Time with Strategies To Improve Nurse Documentation*, PPS ALERT FOR LONG-TERM CARE, NOV. 2009, at 1, 4, http://www.vanhalemgroupp.com/?PPSA%2011_09.pdf. “Many nursing homes created a specific role, the MDS coordinator, to coordinate completion of the RAI in order to maximize reimbursement.” Mary L. Piven et al., *MDS Coordinator Relationships and Nursing Home Care Processes*, W. J. NURSING RES. 294, 295 (2006) (citation omitted).

82. *Id.*

sary for every hour of patient care in a SNF.⁸³ Administrative tasks take extensive time and effort, which tends to put a strain on facilities that should be focusing on resident care.

C. Legislation and Regulation To Improve Nursing Home Quality

Some legislative actions have been implemented to improve the nursing home industry.⁸⁴ During the 1960s, many nursing home spots, also referred to as “beds,” were made available through public funds; however, the nursing homes had very little regulation from the federal government.⁸⁵ The federal government had minimal requirements for nursing homes that received funds from Medicare and Medicaid, but, aside from this, the states could expand on the regulations as they saw fit.⁸⁶ Congress enacted the Older Americans Act of 1965 (OAA)⁸⁷ to help the elderly population by providing states grants to help with development and research projects.⁸⁸ It also created a subset of the U.S. Department of Health and Human Services (HHS) known as the Administration on Aging.⁸⁹ The Omnibus Budget Reconciliation Act of 1987 (OBRA)⁹⁰ was passed to improve nursing homes’ standards.⁹¹ In addition, the Nursing Home Reform Act⁹² provided various rights for nursing home residents and established minimum standards for the services provided to them.⁹³ For example, the Nursing Home Reform Act implemented periodic assessments and care plans for each patient and created the Residents’ Bill of Rights, which enumerated privacy rights, the right to be free from abuse and neglect, and the right to freely communicate.⁹⁴ The state surveying process, which rates facilities and cites them for deficiencies, was also implemented to correct

83. *Id.* at 2.

84. Bassen, *supra* note 60, at 189–93 (discussing 42 C.F.R. § 483 (2009) and the history of New York regulations).

85. *Id.* at 189.

86. *Id.*

87. Pub. L. No. 89-73, 79 Stat. 218 (codified as amended at 42 U.S.C. §§ 3001–58ff (2012)).

88. Bassen, *supra* note 60, at 193.

89. *Id.*

90. Pub. L. No. 100-203, 101 Stat. 1330 (codified as amended in scattered sections of 42 U.S.C.).

91. Steven M. Levin & John M. Rushing, *Litigating Nursing Home Malpractice*, GPSOLO July/Aug. 2008, at 42, 43.

92. Pub. L. No. 100-203, §§ 4201–18, 101 Stat. at 1330-160 to -220 (codified as amended in scattered sections of 42 U.S.C.).

93. Martin Klauber & Bernadette Wright, *The 1987 Nursing Home Reform Act*, AARP (Feb. 2001), http://www.aarp.org/home-garden/livable-communities/info-2001/the_1987_nursing_home_reform_act.html.

94. *Id.*

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known flaws within facilities.⁹⁵ Although some critics believe OBRA and the Nursing Home Reform Act did not go far enough to improve nursing homes, the regulations provided individuals with a standard of how to evaluate quality in nursing homes.⁹⁶ For example: “One key aspect of OBRA is the requirement that a resident’s condition should not worsen as a result of being placed in a nursing home.”⁹⁷

More recently, the Patient Protection and Affordable Care Act (ACA)⁹⁸ was implemented with the goal of putting “consumers back in control of their health care.”⁹⁹ The ACA aims to improve quality, lower costs, increase access to health care, and put consumer protections in place to make health care safer.¹⁰⁰ As part of the ACA, President Obama signed the Nursing Home Transparency and Improvement Act of 2009 (Transparency Act)¹⁰¹ into law, which is arguably the biggest reform in nursing home care in the last twenty years.¹⁰² The Transparency Act requires all facilities with Medicare beds to produce information about any of its organizational members.¹⁰³ It also requires organizations to have a compliance and ethics program to prevent violations.¹⁰⁴ Additionally, information is more streamlined and accessible on the CMS website to better inform residents and their families.¹⁰⁵ This information is helpful to those parties because some larger nursing homes have created complex corporate structures to protect themselves from litigation, so this information has become increasingly difficult to obtain.¹⁰⁶ The CMS changes will promote nursing home transparency and ensure that families of nurs-

95. *Id.*

96. See Levin & Rushing, *supra* note 91, at 43–44.

97. *Id.* at 44.

98. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered section of 26 and 42 U.S.C.).

99. *Key Features of the Affordable Care Act*, U.S. DEP’T HEALTH & HUMAN SERVS., <http://www.hhs.gov/healthcare/facts/timeline/index.html> (last reviewed Nov. 18, 2014).

100. *Id.*

101. Pub. L. No. 111-148, §§ 6101–07, 124 Stat. at 699–713 (2010).

102. CAROLYN TOOMEY, ONE BEACON, HOW THE NURSING HOME TRANSPARENCY AND IMPROVEMENT ACT WILL IMPACT NURSING HOMES 3, <http://www.onebeaconpro.com/sites/OneBeaconPro/blind/OBPI%20BI%20white%20paper.pdf> (“Today we are seeing the most sweeping Health Care Reform changes in more than 20 years. Passed in March 2010, the Patient Protection and Affordable Care Act includes several provisions specific to nursing homes with the most significant being The Nursing Home Transparency and Improvement Act.”)

103. Russell S. Balisok & Peter G. Lomhoff, *Understanding Actions Against Skilled Nursing Facilities*, in RUSSELL S. BALISOK ET AL., CALIFORNIA ELDER LAW LITIGATION: AN ADVOCATE’S GUIDE 2-1, 2-25 (Sheryl Phipps ed. 2014) (citing 42 U.S.C. § 1320a-3(c) (2012)).

104. *Id.* (citing 42 U.S.C. § 1320a-7j(b)).

105. *Id.* (citing 42 U.S.C. §§ 1320a-7j(g), 1395i-3(i), 1396r(i)).

106. Levin & Rushing, *supra* note 91, at 43.

ing home residents know who owns and operates the facilities if they do decide to pursue legal action.¹⁰⁷

The ACA also introduced the Patient Safety and Abuse Prevention Act (Safety Act)¹⁰⁸ and the Elder Justice Act of 2009,¹⁰⁹ which have similarly impacted SNFs.¹¹⁰ The Safety Act enforces a system of criminal background checks for all employees “working in nursing homes and other long-term care” facilities.¹¹¹ The Elder Justice Act, originally proposed by Congress in 2007 and finally signed into law in March 2010, is a bipartisan initiative to improve the quality of care in nursing homes and eliminate abuse and neglect.¹¹² Some of the Elder Justice Act’s goals include: (1) providing federal funds for State Adult Protective Services (APS); (2) ensuring that all states have an APS office through HHS; and (3) implementing other initiatives, including grants, to help curb elder abuse and neglect.¹¹³ The impact of the ACA is yet to be determined because it has been implemented in phases.¹¹⁴

Since December 2008, nursing home ratings have been based on the “5-Star Quality System” in all fifty states and Washington, D.C.¹¹⁵ Each facility receives a certain number of stars in three different categories: “state-conducted health inspections, how much time nurses spend with residents and the quality of medical care.”¹¹⁶ Five-star nursing homes are said to be the best, whereas one-star facilities are

107. See Balisok & Lomhoff, *supra* note 103, at 2-25 (citing 42 U.S.C. § 1320a-3(c)).

108. Pub. L. No. 111-148, § 6201, 124 Stat. 119, 721-27 (2010) (codified as amended at 42 U.S.C. § 1320a-7l).

109. *Id.* §§ 6701-03, 124 Stat. at 782-804 (codified as amended in scattered sections of 42 U.S.C.).

110. See *id.*

111. *Id.*

112. Bassen, *supra* note 60, at 192.

113. *Id.*

114. The Scope of [the ACA] is so broad that it will be years before all of its provisions will be fully implemented and its overall ramifications fully understood. Furthermore, the federal government will promulgate regulations over the next few years that will clarify [the ACA] and give more detailed guidance on how many of its provisions are to be implemented.

The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs, LEGIS. ANALYST’S OFF. (May 13, 2010), http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.aspx. See generally *Key Features of the Affordable Care Act by Year*, *supra* note 99 (listing the key provisions of the ACA by year).

115. Avery Comarow, *FAQ: How We Rate Nursing Homes*, U.S. NEWS & WORLD REP. (Feb. 26, 2014), <http://health.usnews.com/health-news/best-nursing-homes/articles/2014/02/26/faq-how-we-rate-nursing-homes>.

116. *Id.*

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the worst.¹¹⁷ In October 2014, CMS reported that it would make changes to the 5-Star Quality System because there was too much “self-reported, unverified data.”¹¹⁸ Since 2015, nursing homes must enter staffing data into an electronic system that can be verified by the facility’s payroll.¹¹⁹ Officials will begin an auditing program to ensure that quality ratings regarding each individual patient are accurate.¹²⁰ Greg Crist of the American Health Care Association, a lobbying group that works on behalf of for-profit and not-for-profit nursing homes, says that quality improvements have already occurred from the 5-Star Quality System, but the auditing program will create greater accuracy and help reassure patients and families that changes are being made.¹²¹

At the state level, the Department of Health (DHS) conducts nursing home health inspections on behalf of CMS, which generally occur at least every twelve to fifteen months, to regulate facilities with Medicare and Medicaid beds.¹²² DHS also investigates complaints from residents or their families.¹²³ Individual states also have different Medicaid regulations, so health care providers in each state must

117. *Five-Star Quality Rating System*, CTRS. FOR MEDICAID & MEDICARE SERVS., <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html> (last modified July 16, 2015).

118. Katie Thomas, *Medicare Revises Nursing Home Rating System*, N.Y. TIMES, Oct. 6, 2014, http://www.nytimes.com/2014/10/07/business/medicare-alters-its-nursing-home-rating-system.html?_r=0.

119. *See id.*

120. *Id.*

121. *Id.* (quoting Greg Crist, spokesman for the American Health Care Association).

122. *Nursing Home/Skilled Care Facility Directory: Compare Ratings, Survey Reports, Evaluate Inspection Rankings*, CARE PATHWAYS, <http://www.carepathways.com/nhg-state.cfm> (last visited Feb. 3, 2016) (“Each state inspects nursing homes at least every 12-15 months to assess compliance with federal standards of care such as adequacy of staffing, quality of care and cleanliness of facilities.”); *see, e.g., About Us-Licensing & Certification*, CA.GOV, <https://hfcis.cdph.ca.gov/aboutUs.aspx> (last visited Feb. 4, 2016) (noting that the California Department of Public Health inspects nursing homes, on average, “every 12 months, but is more frequent for facilities with poor inspection results and numerous verified complaints.”); *Consumer Guide to Long Term Care*, MD. HEALTH CARE COMM’N, <http://mhcc.maryland.gov/consumerinfo/longtermcare/Definitions.aspx> (last visited Aug. 12, 2015) (discussing how Maryland’s health care commission inspects nursing facilities every twelve to fifteen months); *Who Regulates Nursing Homes?*, ILL. DEP’T PUB. HEALTH, <http://www.idph.state.il.us/healthca/nhregulate.htm> (last visited Feb. 4, 2016) (“Nursing homes are inspected at least once every six to 15 months. The state average is once every 12 months.”).

123. *See, e.g., About Us-Licensing & Certification*, *supra* note 122 (discussing California’s process regarding the investigation of complaints); *Consumer Guide to Long Term Care*, *supra* note 122 (discussing Maryland’s process regarding the investigation of complaints); *Health Facilities Complaints*, COLORADO DEP’T PUB. HEALTH & ENVIRONMENT, <https://www.colorado.gov/pacific/cdph/health-facilities-complaints> (last visited Feb. 3, 2016) (discussing how to file a complaint regarding a health care facility with the Colorado Department of Health); *Reporting a Complaint About a Health Care Facility*, IND. STATE DEP’T HEALTH, <http://www.in.gov/isdh/>

comply with both state and federal Medicaid rules.¹²⁴ The facility is given a rating by CMS based on the severity and scope of the deficiencies.¹²⁵

D. Nursing Home Litigation Trends

Although there have been legislative attempts to improve quality in the nursing home industry, quality has remained a critical issue and claim frequency has steadily increased.¹²⁶ Especially in the last two decades, families, as well as attorneys, have relied on litigation to combat elder abuse in nursing home facilities and to hold these facilities accountable.¹²⁷ In 2003, “[a]ttorneys reported substantial increases over the past five years in both the number of nursing-home claims they handled and the average size of recoveries.”¹²⁸ Consequently, nursing home litigation has become a “new and growing industry.”¹²⁹ However, nursing home litigation did not always yield a lot of money.¹³⁰ This changed in the 1980s when lawyers James Wilkes and Tim McHugh initiated a strategy involving a Florida law that set standards for nursing home care and gave plaintiffs the ability to sue for legal fees.¹³¹ Florida’s 1976 residents’ rights law helped Wilkes and McHugh win their first nursing home client a confidential settlement.¹³² The statute allowed plaintiffs to “sue for neglect, as a separate cause of action beyond simple negligence.”¹³³ Nursing homes began to settle, and many firms, like Wilkes & McHugh, grew and spread across the United States.¹³⁴

21533.htm (discussing the same process in Indiana); *Who Regulates Nursing Homes?*, *supra* note 122 (discussing the same process in Illinois).

124. *Eligibility*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> (last visited Aug. 12, 2015).

125. *Id.* “[CMS] calculate[s] a total health inspection score for facilities based on the facility’s weighted deficiency score and number of repeat revisits needed.” CTRS. FOR MEDICAID & MEDICARE SERVS., DESIGN FOR NURSING HOME COMPARE FIVE-STAR QUALITY RATING SYSTEM: TECHNICAL USERS’ GUIDE 4 (Feb. 2015), <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf>.

126. AON RISK SOLUTIONS, 2013 LONG TERM CARE: GENERAL LIABILITY AND PROFESSIONAL LIABILITY ACTUARIAL ANALYSIS 5 (2013).

127. *See* Stevenson & Studdert, *supra* note 7, at 223–26.

128. *Id.* at 223.

129. *Id.* at 224.

130. *Id.*

131. Dee McAree, *Carving Out a Lucrative Niche*, NAT’L L.J. (July 26, 2004), <http://www.nationallawjournal.com/id=900005411840/Carving-out-a-lucrative-niche>.

132. *See id.*

133. *Id.*

134. *See* Stevenson & Studdert, *supra* note 7, at 224–25.

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It is usually family members, as opposed to residents, who initiate personal injury claims against nursing homes.¹³⁵ Residents' children bring approximately 65% of nursing home claims, and residents' spouses bring another 20% of claims.¹³⁶ Most allegations against nursing homes are for "death, pressure ulcers[,] . . . dehydration or weight loss, emotional distress, and falls."¹³⁷ Many nursing home claims are rooted in common law, but almost one-half are brought under state statutes, such as residents' rights and elder abuse laws.¹³⁸ Additionally, only 10% of nursing home claims actually make it to trial, which is typical for medical malpractice claims.¹³⁹ Nevertheless, nine out of ten plaintiffs receive some type of compensation.¹⁴⁰ Noneconomic damages encompass 80% of the recovery—a number almost double that found in regular medical malpractice cases.¹⁴¹ Moreover, punitive damages are also more prevalent in nursing home cases; 18% of the payouts result in punitive damages to the nursing home.¹⁴²

Despite the prevalence and high cost of litigation in nursing home cases, the question remains whether nursing home litigation is actually doing its job to induce and improve quality care for nursing home residents.¹⁴³ Plaintiffs' attorneys and elder activists argue that lawsuits provide accountability and ensure that nursing homes provide quality care.¹⁴⁴ Nevertheless, nursing home providers and health care defense attorneys suggest that the lawsuits do little to promote quality care and may actually diminish quality due to the harsh financial burdens litigation imposes on an industry that already suffers from federal budget cuts.¹⁴⁵

Brian Reddick, a nursing home litigator, stated that nursing home chains may be "putting revenue over residents" because for-profit nursing homes "skimp on patient care to boost profits."¹⁴⁶ Plaintiffs' attorneys' goal is to help patients who are harmed by facilities that cut

135. David M. Studdert & David G. Stevenson, *Nursing Home Litigation and Tort Reform: A Case for Exceptionalism*, 44 GERONTOLOGIST 588, 589 (2004).

136. *Id.* (citing Stevenson & Studdert, *supra* note 7).

137. *Id.*

138. *Id.*

139. *Id.* at 590.

140. *Id.*

141. Studdert & Stevenson, *supra* note 135, at 590.

142. *Id.*

143. Stevenson & Studdert, *supra* note 7, at 226.

144. *Id.* at 225.

145. *Id.*

146. Smith, *supra* note 10 (quoting Brian Reddick).

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corners on quality.¹⁴⁷ Additionally, there is a concern that slowing nursing home litigation will protect big businesses over vulnerable elders.¹⁴⁸ Plaintiffs' attorneys feel that they are doing their jobs to protect individuals.¹⁴⁹ Reddick, who has secured over \$100 million dollars in jury awards for his nursing home litigation clients, stated: "I think we have made a notable difference."¹⁵⁰

However, those in the nursing home industry believe that predatory litigation is "putting the screws to an industry already bedeviled by slim margins."¹⁵¹ In 2011, there was an 11.1% cut in Medicare reimbursements and then a further 2% cut in 2013.¹⁵² In an industry that is 80% reliant on federal funding, the impact of budget cuts can be devastating.¹⁵³ Moreover, litigation costs only add to this financial concern.¹⁵⁴ "Our members are looking around, saying we need to survive."¹⁵⁵ The nursing home industry also feels targeted by attorneys who recover large sums of money in nursing home liability cases.¹⁵⁶ Operators and industry groups have stated that "lawsuits line attorneys' pockets while doing little to improve the quality of care."¹⁵⁷

E. Elder Abuse Definitions Vary by State

A state's elder abuse definition may induce or reduce the number of nursing home lawsuits that take place within that particular state.¹⁵⁸ Currently, each state is able to implement its own definition of elder

147. *Id.*

148. See, e.g., Michael L. Rustad, *Heart of Stone: What Is Revealed About the Attitude of Compassionate Conservatives Toward Nursing Home Practices, Tort Reform, and Noneconomic Damages*, 35 N.M. L. REV. 337, 340 (2005) ("[U]nfortunately, [tort reformers] are more concerned about saving corporate profits than about preventing an epidemic of pain and suffering.").

149. Smith, *supra* note 10.

150. *Id.*

151. *Id.* (referring to the 2011 cuts in Medicaid payments and Medicare reimbursements).

152. *Id.*

153. *Id.* (quoting Greg Crist, spokesman for the American Health Care Association).

154. *Id.*

155. Smith, *supra* note 10 (quoting Greg Crist, spokesman for the American Health Care Association).

156. *Id.* (providing HCR Manor Care, Inc. as one example).

157. *Id.*

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California is currently grappling with this very issue. Tort reforms passed in that state in 1975 capped noneconomic damages awards in medical malpractice verdicts at \$250,000. However, the limit does not apply when plaintiffs can show that the defendants' behavior consisted of egregious acts of abuse involving "recklessness, oppression, fraud, or malice." The debate in California centers on whether the state's (more permissive) elder-abuse statute preempts the application of this cap in the case of nursing home claims.

Studdert & Stevenson, *supra* note 135, at 593.

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abuse, so a clear-cut answer as to what actually constitutes elder abuse is missing.¹⁵⁹ Some states have narrow definitions, in which elder abuse is very specifically stated, while other states have broader definitions, which ultimately cause plaintiffs' attorneys to sue more frequently.¹⁶⁰ Further, "[t]he frequency of elder neglect in health care facilities varies by state. This may be correlated with interstate inconsistencies in laws regarding civil and criminal liability for elder abuse and neglect."¹⁶¹ Although each state has some type of elder abuse prevention law in place, there is no uniformity among the states, which creates confusion as to what actions actually constitute abuse or neglect.¹⁶²

The terms "abuse" and "neglect" have different meanings in elder abuse law.¹⁶³ The Code of Federal Regulations (CFR) defines abuse as: "the *willful* infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."¹⁶⁴ The CFR defines neglect as: "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."¹⁶⁵ These federal definitions seem to focus on intentional and quasi-criminal acts.

Abuse and neglect are defined differently in state statutes as opposed to the CFR's definitions.¹⁶⁶ For example, Arizona defines abuse as:

- (a) Intentional infliction of physical harm.
- (b) Injury caused by *negligent acts* or omissions.
- (c) Unreasonable confinement.
- (d) Sexual abuse or sexual assault.¹⁶⁷

Therefore, under Arizona state law, simple negligence constitutes abuse.¹⁶⁸ Arizona defines neglect as "a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health."¹⁶⁹

159. Bassen, *supra* note 60, at 198.

160. *See id.* at 196 n.135, 198–99.

161. *Id.* at 198 (footnote omitted).

162. *Id.* at 204.

163. 42 C.F.R. § 488.301 (2014).

164. *Id.* (emphasis added).

165. *Id.*

166. *See, e.g.*, ARIZ. REV. STAT. ANN. § 46-451 (2014); 320 ILL. COMP. STAT. 20/2 (2014); KY. REV. STAT. ANN. § 209.020 (LexisNexis 2013); 35 PA. STAT. AND CONS. STAT. ANN. § 10225.103 (West 2012).

167. ARIZ. REV. STAT. ANN. § 46-451 (emphasis added).

168. *Id.*

169. *Id.*

For another example, Pennsylvania law defines abuse as “[t]he occurrence of one or more of the following acts:

- (1) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
- (2) The *willful deprivation* by a caretaker of goods or services which are necessary to maintain physical or mental health.
- (3) Sexual harassment, rape or abuse, as defined in the [Protection from Abuse Act].”¹⁷⁰

Pennsylvania state law also includes negligence in its definition of abuse.¹⁷¹ Unlike Arizona or Pennsylvania, Illinois defines abuse as causing “any physical, mental or sexual injury to an eligible adult, including exploitation of such adult’s financial resources. . . . Nothing in this Act shall be construed to mean that an eligible adult is a victim of abuse because of health care services provided or not provided by licensed health care professionals.”¹⁷² Likewise, Kentucky defines abuse as “the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.”¹⁷³ Neither Illinois¹⁷⁴ nor Kentucky¹⁷⁵ includes negligence in its state definition of elder abuse.

The federal government has created definitions for elder abuse and neglect, but “there is still no comprehensive federal legislation addressing elder abuse and neglect. . . . [I]t is essential that there be a ‘coordinated,’ guided approach at the federal level.”¹⁷⁶

III. ANALYSIS

To create consistency across the United States, the federal government must create a uniform definition for elder abuse that must be adopted by the state legislatures. This part analyzes this issue by exploring several aspects: (1) litigation’s relationship to quality care; (2) the large financial burden that litigation places on health care facili-

170. 35 PA. STAT. AND CONS. STAT. ANN. § 10225.103.

171. *Id.* The Pennsylvania Adult Protective Services Act defines “neglect” as:

The failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health. No older adult who does not consent to the provision of protective services shall be found to be neglected solely on the grounds of environmental factors which are beyond the control of the older adult or the caretaker, such as inadequate housing, furnishings, income, clothing or medical care.

Id. § 10225.103.

172. 320 ILL. COMP. STAT. 20/2 (2014).

173. KY. REV. STAT. ANN. § 209.020 (LexisNexis 2013).

174. 320 ILL. COMP. STAT. ANN. 20/2.

175. KY. REV. STAT. ANN. § 209.020.

176. Bassen, *supra* note 60, at 191 (footnote omitted).

ties; (3) the difficulties associated with varying definitions; (4) nursing homes as targets for elder abuse; (5) California's elder abuse laws and their impact on physicians; and (6) proposals for a model federal statute.

A. *Litigation Is Not Significantly Increasing Quality Care in Nursing Homes*

Evidence makes a compelling showing that litigation does not increase quality care in nursing homes.¹⁷⁷ Nursing homes with more deficiencies¹⁷⁸ are sued more often than those with fewer deficiencies, but the difference is marginal.¹⁷⁹ In a 2011 study defining the relationship between negligence litigation and quality, nursing homes with the lowest deficiency ratings had a 40% chance of being sued each year.¹⁸⁰ In contrast, nursing homes with the highest deficiency ratings had a 47% chance of being sued, which is only a 7% greater risk than the nursing homes with the lowest deficiency ratings.¹⁸¹ Due to the negligible difference in risk rates, the desire to provide quality care may not actually be driven by the threat of litigation.¹⁸² Litigation is typically expected to create fear and incentivize facility caregivers to take more precaution;¹⁸³ however, if high-performing nursing homes are being sued at comparable rates to low-performing nursing homes, the

177. See, e.g., Stevenson & Studdert, *supra* note 7, at 226–27 (“In states with a high volume of litigation, the diversion of substantial resources now required to defend and pay nursing home lawsuits is likely to have an independent, negative impact on quality.”); Studdert et al., *supra* note 14, at 1248 (“If, as we found in the context of nursing homes, providers who deliver low-quality care face only marginally higher exposure to litigation than do providers who deliver high-quality care, deterrence may be disrupted at the outset.”).

178. If a nursing home facility does not meet a certain standard, the inspector issues a deficiency citation. *Inspection Results*, MEDICARE.GOV, <http://www.medicare.gov/NursingHomeCompare/About/Inspection-Results.html?AspxAutoDetectCookieSupport=1> (last visited Aug. 13, 2015). The federal government could then impose a penalty. For example, Medicare could deny a payment, issue a fine, or provide a state monitor. *Id.* State governments could also impose certain penalties for deficiencies. *Id.*

179. Studdert et al., *supra* note 14, at 1246–47, 1249 fig.1A.

180. *Id.* at 1246, 1249 fig.1A (noting that nursing homes with the lowest deficiency ratings are in the ninetieth percentile).

181. *Id.* (noting that nursing homes with the highest deficiency ratings are in the tenth percentile).

182. *Id.* at 1250 (“The results of this study raise questions about the capacity of tort litigation to provide incentives for improving the quality and safety of nursing home care. It is far from clear that superior performance will be regarded with substantially lower risks of being sued.”).

183. *Id.* at 1248 (“Tort theory suggests that litigation induces defendants to be more careful and warns others to take precautions. But to be effective, this deterrent function logically requires a degree of precision. If, as we found in the context of nursing homes, providers who deliver low-quality care face only marginally higher exposure to litigation than do providers who deliver high-quality care, deterrence may be disrupted at the outset.” (footnotes omitted)).

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incentive to produce better care for fear of liability is diminished.¹⁸⁴ Suing and threatening to sue nursing homes has not proven effective; it is time to go back to the drawing board. This Comment suggests that the first step is to create a uniform elder abuse statute that puts all states on an equal playing field.

1. *Litigation Trends Are Tied to Tort Reform Not Elder Abuse Numbers*

It is crucial to look at other factors that may affect the prevalence of litigation; one of those factors is tort reform.¹⁸⁵ Plaintiffs' attorneys are less likely to bring nursing home abuse cases in states that have implemented many tort reform mechanisms.¹⁸⁶ This is because the more tort reform mechanisms in place within a state, the fewer nursing home abuse cases are brought on behalf of nursing home residents.¹⁸⁷ "Conservative jurisdictions with long standing tort limits are less economically attractive to attorneys. The [plaintiff-nursing home] firms have focused their attention on venues with no tort limits, less mature tort laws or more liberal judiciaries."¹⁸⁸ This implies that nursing home litigation may be tied to tort reform instead of the actual number of elder abuse cases occurring.

Tort reform includes "placing caps on non-economic damages, reforming the collateral source rule,¹⁸⁹ limiting attorney contingency fees, specifying statutes of limitations, making apology statements inadmissible, and changing rules relating to forum shopping, joint and several liability, and expert witnesses[.]" and it is designed to reduce the number of tort cases and costs associated with those cases.¹⁹⁰ Typically, tort reform is implemented in states that have been hard hit by litigation.¹⁹¹ Therefore, states with tort reform have fewer elder abuse

184. *Id.*

185. AON RISK SOLUTIONS, *supra* note 126, at 5.

186. *Id.*

187. *Id.*

188. *Id.*

189. The collateral-source rule is a doctrine standing for the notion "that if an injured party receives compensation for the injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay." *Collateral-Source Rule*, BLACK'S LAW DICTIONARY (10th ed. 2014).

190. AM. ACAD. OF ACTUARIES, WHAT IS TORT REFORM?: AN ACTUARIAL PERSPECTIVE ON MEDICAL PROFESSIONAL LIABILITY REFORMS 1 (Oct. 2009), http://www.actuary.org/files/tort_fact_oct09.4.pdf/tort_fact_oct09.4.pdf.

191. See CONG. BUDGET OFFICE, THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES (June 2004), https://www.cbo.gov/sites/default/files/108th-congress-2003-2004/reports/report_2.pdf (citations omitted) ("Since the mid-1980s, a large majority of states have enacted statutes to restrict tort lawsuits. Those statutes were enacted in response to problems in insurance costs and availability. The idea behind those changes was that limiting the liability expo-

lawsuits than those without tort reform measures,¹⁹² even though there is likely a similar number of abusive actions occurring among them.¹⁹³ The fact that states' litigation trends are tied to tort reform and not to the actual number of elder abuse cases occurring¹⁹⁴ may imply that elder abuse laws are not doing their job of protecting elders. Instead, attorneys may take nursing home abuse cases for financial gain rather than promoting quality care for the elderly population.¹⁹⁵ Thus, despite proponents' arguments, these elder abuse statutes are not a sufficient means of protecting the elderly population.

Wilkes & McHugh has a history of entering and leaving certain states in response to tort reform.¹⁹⁶ The Florida-based firm has spent the last twenty years winning large nursing home cases.¹⁹⁷ Consumers

sure of firms would reduce liability insurance premiums." (footnote omitted). "In response to the criticisms of medical malpractice litigation and the medical malpractice crisis of the 1970s and 1980s, physicians and malpractice insurance carriers began to lobby heavily for changes to reduce medical malpractice tort liability." David M. Ottenwess et al., *Medical Malpractice Tort Reform*, RADIOLOGY MGMT., Mar./Apr. 2011, at 30, 31, http://www.thehealthlawpartners.com/files/rm332_p30-36_features.pdf.

192. AON RISK SOLUTIONS, *supra* note 126, at 5.

193. Available data from state Adult Protective Services (APS) agencies show an increase trend in the reporting of elder abuse. Despite accessibility of APS in all 50 states (whose programs are quite different), as well as the reporting laws for elder abuse in most states, an overwhelming number of cases of abuse, neglect, and exploitation go undetected and untreated each year.

Statistics/Data, NAT'L CTR. ON ELDER ABUSE, ADMIN ON AGING, <http://www.ncea.aoa.gov/library/data/#problem> (last visited Jan. 30, 2016). "Unfortunately, we simply do not know for certain how many people are suffering from elder abuse and neglect." *Id.* "[A]buse and neglect are widespread across residential long-term care settings. However, there is no definitive evidence about prevalence. There are several reasons for this. First, existing estimates are based on reports to a multiplicity of agencies, each of which uses different definitions, investigative protocols, and standards of proof." Catherine Hawes, *Elder Abuse in Residential Long-Term Care Settings: What Is Known and What Information Is Needed?*, in *ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA* 446, 469-70 (Richard J. Bonnie & Robert B. Wallace eds., 2003), http://www.ncbi.nlm.nih.gov/books/NBK98802/pdf/Bookshelf_NBK98802.pdf

194. *See id.*

195. *See* Holli W. Haynie, *Out-of-State Plaintiff Firms Increasingly File Nursing Home Lawsuits*, E. TENN. MED. NEWS (Dec. 2006), <http://www.easttennessee.medicalnewsinc.com/news.php?viewStory=735> ("Usually what we're seeing, suits are brought up in areas where there is a flurry of out-of-state firms coming in," explained Ron Taylor, executive director of the Tennessee HealthCare Association (THCA). "There are no caps on punitive or economic damages, there is no limit on attorney's fees—without those limits, there is incentive to sue.").

196. *See* Scott Shepard, *Nursing Homes Brace for Legal Assault*, MEMPHIS BUS. J. (June 15, 2001), <http://www.wilkesmchugh.com/nursing-homes-brace-legal-assault.html> ("[An attorney who has represented several cases against Wilkes & Hughes] believes the sequence of states targeted by Wilkes & McHugh has been based on their burden of proof requirements, and the lack of limits on awards for pain and suffering.").

197. Richard L. Peck, *LTC's 10 Most Influential People*, LONG-TERM LIVING MAG. (Jan. 1, 2011), <http://www.ltlmagazine.com/article/ltes-10-most-influential-people?page=show>.

and plaintiffs' attorneys typically disfavor tort reform mechanisms because the reform makes it harder for consumers to access the courts and often caps damages available to them.¹⁹⁸ The irony is that this firm and others like it increase the popularity of tort reform by encouraging facilities to fearfully believe that they will ultimately be sued for nursing home elder abuse claims.¹⁹⁹ This is because tort reform results in nursing home cases costing more than they are worth (e.g., damage caps), which, in turn, causes fewer attorneys to take the cases.²⁰⁰ For example, evidentiary obstacles are hard to overcome; "[e]xperts on medical, standard of care, and damages issues can cost \$100,000 or more."²⁰¹ Additionally, nursing home residents often have no future income or lost wages, so economic damages are usually not an option, which makes elder abuse cases less attractive.²⁰² Moreover, it appears some plaintiffs' firms have disappeared from states that have implemented tort reform measures.²⁰³ If these firms' goals were to help residents and patients, as they claim, it seems they would be staying in these areas regardless of the statute in place. According to Roger Glasgow, an Arkansas nursing home defense attorney, Wilkes & McHugh has "single-handedly done the greatest disservice to nursing homes in states where they operate than any other source."²⁰⁴

Alternatively, elder abuse activists may argue that the motivation driving attorneys to take nursing home abuse cases does not matter as long as they choose to take them.²⁰⁵ It is a commonly accepted notion

198. See, e.g., Adam Feit, *Tort Reform, One State at a Time: Recent Developments in Class Actions and Complex Litigation in New York, Illinois, Texas, and Florida*, 41 LOY. L.A. L. REV. 899, 899 (2008) (examining the attack against tort reform in the 1970s and 1980s).

199. Carl Cronan, *Bedside Advocate*, BUS. OBSERVER (Feb. 11, 2011), <http://www.businessobserverfl.com/section/detail/bedside-advocate/> ("Long-Term Living notes that even though Wilkes' verdicts have led to tort reform laws in several states limiting judgments and lawyer fees, 'the big cases keep coming . . .'").

200. McAree, *supra* note 131 ("Due to tort reform in Texas and a number of other states, most nursing home cases cost more than they're worth.").

201. Wrosch, *supra* note 52, at 15.

202. *Id.*

203. McAree, *supra* note 131 ("Yet more and more lawyers . . . are moving away from nursing home litigation. . . . Wilkes & McHugh, whose nursing home practice has sometimes reached 90% of its overall caseload, has started to expand a smaller practice in commercial litigation and deceptive trade practices.").

204. *Id.* (quoting Roger Glasgow).

205. See, e.g., Daniel L. Madow, *Why Many Meritorious Elder Abuse Cases in California Are Not Litigated*, 47 U.S.F.L. REV. 619, 625 (2013) ("Even if elder abuse is reported and properly investigated, victims then face the challenge of finding a civil litigation attorney who is willing to take the case. . . . If the case will be expensive to litigate, and the victim is unable to finance the litigation expenses, the attorney may balk at risking a significant amount of money out-of-pocket, in addition to the time and effort associated with handling a case, for which he or she

that most professionals want to make money from their jobs. But, the real purpose of these laws gets lost when the motivating force behind these cases is financial gain and when the laws that control the demand of these cases are subject to significant tort reform.²⁰⁶ The focus then moves away from protecting vulnerable elders and, instead, centers on compensation. By creating a uniform federal statute that would be adopted by all states, the focus could once again be placed on the real issue: caring for elders.

2. *Litigation Is Driving Up Costs of Nursing Home Care*

Law firms targeting states with favorable legal climates are driving up the costs of providing nursing home care in those states.²⁰⁷ According to a study conducted by Aon, one of the leading providers of risk management, insurance, and human resources solutions, liability costs increased by 5% in 2014.²⁰⁸ Aon's study, which analyzed sixteen states for costs associated with liability, found that Kentucky had the highest loss rate projected for 2014 at a deficit of \$8,090 per occupied bed.²⁰⁹ Kentucky's constitution prohibits noneconomic damages; thus, Kentucky has been a plaintiff-friendly legal environment for nursing home abuse victims and subsequent litigation.²¹⁰

Alternatively, Tennessee implemented tort reform in 2011, and, soon after, providers noticed an increase in plaintiffs' attorney advertising before the reform became effective.²¹¹ In 2014, Tennessee's loss rate was projected at a deficit of \$2,870 per occupied bed.²¹² Texas is even more drastic, with a deficit of \$300 per occupied bed.²¹³ This is likely due to Texas's tort reform of 2003, which placed a \$250,000 cap

may never receive compensation." (footnote omitted)). Attorneys are not likely to take a case in which they will not receive compensation. *Id.*

206. *See, e.g.*, Scott Shepard, *Nursing Homes Brace for Legal Assault*, MEMPHIS BUS. J. (June 15, 2001), <http://www.wilkesmchugh.com/nursing-homes-brace-legal-assault.html> (discussing the tactics used by Wilkes & McHugh).

207. *See* AON RISK SOLUTIONS, *supra* note 126, at 5.

208. *Id.* at 5, 7 fig. ("Long term care loss rates are increasing by 5% annually.").

209. *Id.* ("At \$8,090 per occupied bed, Kentucky has the highest loss rate among those profiled in this study and the third highest frequency of claims.").

210. *Id.* at 5. ("The state is an attractive venue for the plaintiff's bar because its constitution prohibits limits on non-economic damages. Therefore, one of the most effective tools to limit claim cost growth is not an option.").

211. *Id.* at 6. ("Tennessee's tort limits became effective in October 2011. Providers noted an increase in advertising that encouraged claimants to come forward before the limits were in place.").

212. "Tennessee's loss rate is \$2,870, fifth highest of the profiled states." *Id.* at 6.

213. AON RISK SOLUTIONS, *supra* note 126, at 42 fig.

on noneconomic damages.²¹⁴ As shown among these states' disparity in litigation costs per bed, litigation is more prevalent where tort reform mechanisms have not been implemented.²¹⁵ Thus, it appears that tort reform does not impact the number of elder abuse incidents occurring within the state (that number remains the same); rather, the number of elder-abuse cases brought is dependent on whether a state has implemented tort reform. This disparity also shows the financial burden of litigation on nursing home operators, which may ultimately affect the quality of care provided to residents.²¹⁶

The different litigation trends among the states create multiple issues; not only do they disadvantage certain nursing homes based on location, but they also move protection away from elders who need it in other locations. Litigation costs facilities money, which could be used to care for residents and provide quality care. By creating uniformity among the states, all states would have the same elder abuse definition, which would be a start to promoting equality. The definition must be comprehensive enough so that nursing home residents in each state can sue to protect their rights while also leveling the playing field for nursing homes to protect themselves against liability.

B. Current State Elder Abuse Statutes Are Largely Ineffective

The goal of elder abuse statutes is to reduce abuse against the elderly population in all settings, including nursing homes.²¹⁷ Beginning in the 1980s, states began enacting abuse and neglect laws to protect their elderly residents.²¹⁸ Yet, in recent years, elder abuse has increased considerably in every state.²¹⁹ This begs the question of whether these elder abuse statutes have been effective in protecting the elderly population. As mentioned *supra*, elder abuse is most often committed by close friends and family, not by health care facilities.²²⁰ Still, nursing homes are continuously known for committing elder

214. Terry Carter, *Tort Reform Texas Style*, ABA J. (Oct. 24, 2006, 9:38 AM), http://www.abajournal.com/magazine/article/new_laws_and_med_mal_damage_caps_devastate_plaintiff_and_defense_firms_alik.

215. AON RISK SOLUTIONS, *supra* note 126, at 5–7, 7 fig.

216. *See id.* (“[P]roviders and defense attorneys state, with some empirical justification, that lawsuits are haphazard, do little to improve quality, and impose serious financial burdens.”)

217. *Basics*, CTR. FOR ELDERLY & CTS., <http://www.eldersandcourts.org/Elder-Abuse/Basics/Elder-Abuse-Laws.aspx> (last visited Nov. 23, 2015) (“Both federal and state laws address elder abuse, neglect, and exploitation, but state law is the primary source of sanctions, remedies and protections related to elder abuse.”).

218. *State Laws*, NCEA, <http://www.ncea.aoa.gov/Library/Policy/Law/State/index.aspx> (last visited Nov. 23, 2015).

219. *See Statistics/Data*, *supra* note 53.

220. *Id.*

abuse,²²¹ so it seems that the elder abuse statutes currently in place target the wrong audience.

Elder abuse incidences have increased, but it is important to note that there has been an increase in the number of individuals reporting abuse because there is more transparency in the long-term care industry today than there has been in the past.²²² The increase in the elderly population also plays a significant role in the number of elder abuse claims reported.²²³ Logically, the more elders there are, the more elder abuse will likely occur.²²⁴ These statutes should significantly reduce the incidence of abuse overall; however, that does not seem to be the case. One reason for this is because the variable in state statutes makes it difficult to track elder abuse incidents.

The variation in elder abuse statutes also makes research on abuse less consistent and accurate. "It is difficult to pinpoint exactly what actions or inactions constitute abuse, and the problem remains greatly hidden."²²⁵ Because of the lack of standardization of what actually constitutes abuse and neglect, there is no uniform reporting system, which makes compiling national data or statistics challenging.²²⁶ Independent studies have been critical in helping to understand elder abuse trends.²²⁷ However, the number of U.S. citizens impacted by abuse, neglect, or exploitation remains unknown.²²⁸ Introducing an uniform definition would allow for more research to be conducted so that new and innovative ways to protect elders can be put into action. Data would be more streamlined so that problem areas could be

221. Chen, *supra* note 6, at 215.

222. Doug Alexander, *Predatory Lawsuits Hurt Nursing-Home Patients*, KENTUCKY.COM (July 2, 2012), http://www.kentucky.com/welcome_page/?shf=/2012/07/02/2245596_doug-alexander-predatory-lawsuits.html ("The industry's reward for encouraging oversight and transparency is to invite lawsuits that drive up the cost of doing business and ultimately the cost of care to the very people the regulations are intended to benefit.").

223. Martin J. Gorbien & Amy R. Eisenstein, *Elder Abuse and Neglect: An Overview*, 21 CLINICS IN GERIATRIC MED. 279, 282 (2005) ("Intuitively, it should follow that elder mistreatment is on the rise given a rapidly growing at risk population.").

224. *Elder Abuse*, WORLD HEALTH ORG., <http://www.who.int/mediacentre/factsheets/fs357/en/> (last updated Dec. 2014) ("Globally, the number of cases of elder mistreatment is projected to increase as many countries have rapidly ageing populations whose needs may not be fully met due to resource constraints.").

225. NAT'L CTR. ON ELDER ABUSE, FACT SHEET: ELDER ABUSE PREVALENCE AND INCIDENCE 1 (2005), <http://www.ncea.aoa.gov/resources/publication/docs/finalstatistics050331.pdf>.

226. *Id.*

227. *Id.* ("In the absence of a large-scale nationwide tracking system, studies of prevalence and incidence conducted over the past few years by independent investigators have been crucial in helping us to understand the magnitude of the problem.").

228. *Id.* ("No one knows precisely how many older Americans are being abused, neglected, or exploited. While evidence accumulated to date suggests that many thousands have been harmed, there are no official national statistics.").

targeted, and data would also help educate not only the public, but legislative and political leaders.

C. Elder Abuse Statutes Are Unfairly Targeting Nursing Homes

States with harsh elder abuse statutes put health care providers in nursing home settings at a disadvantage to those in other health care institutions.²²⁹ In hospitals and other health care settings, doctors and nurses can be sued for medical negligence or malpractice.²³⁰ However, “[d]octors who treat nursing home patients also face the risk of a suit alleging ‘elder abuse.’ If the patient’s [sic] in pain, for example, a doctor who’s overly cautious or overly generous about prescribing pain medication could be charged with elder abuse.”²³¹ The Arizona elder abuse statute states that negligence is included in the definition of abuse, which results in consequences for elder caregivers.²³² For that same act of medical negligence in a nursing home, a health care provider can be sued for “abuse” instead of negligence under state elder abuse statutes, which are often more punitive than simple medical negligence statutes.²³³ “Compared to malpractice suits, elder abuse claims can present greater legal dangers: While state laws vary, such claims may not be limited by caps on non-economic damages; they’re more likely to result in punitive damages; and, worst of all, they may not be covered by your malpractice policy.”²³⁴ States are able to bring medical malpractice claims and label them as elder abuse, which provides financial incentives for attorneys but may actually hurt all parties involved.²³⁵ “Every day . . . we see newspaper or TV ads by plaintiffs’ attorneys seeking cases of nursing home neglect

229. See generally Berkeley Rice, *Should You See Nursing Home Patients?*, MED. ECON. (May 6, 2005), http://medicaleconomics.modernmedicine.com/medical-economics/content/should-you-see-nursing-home-patients?id=&sk=&date=&pageID=2&total_page=5 (discussing the disparity).

230. Christian Nordqvist, *What Is Medical Malpractice?* MED. NEWS TODAY, <http://www.medicalnewstoday.com/articles/248175.php> (last updated Sept. 17, 2014) (“Medical malpractice refers to professional negligence by a health care professional or provider in which treatment provided was substandard, and caused harm, injury or death to a patient. In the majority of cases, the medical malpractice or negligence involved a medical error, possibly in diagnosis, medication dosage, health management, treatment, or aftercare.”)

231. Rice, *supra* note 229.

232. ARIZ. REV. STAT. ANN. § 46-451 (2014).

233. *Id.*

234. Rice, *supra* note 229.

235. *Id.* (referencing the television advertisements and newspaper articles from plaintiffs’ attorneys trying to sue for elder abuse in nursing homes). It would hurt all parties involved because the doctors are being sued and do not want to work at nursing homes, so the long-term care sector may begin to lack qualified doctors, which, in turn, causes more quality problems.

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or abuse.”²³⁶ In a time when high-quality nursing home care is needed more than ever, doctors should be incentivized, not disincentivized, to work in a long-term care facility.

In addition, the nursing home industry is already extensively and necessarily regulated at both the state and federal levels. For example, a nursing home must comply with regulations at the state and federal level to maintain its status as a licensed SNF.²³⁷ Each state has a regulatory agency that reviews the standard of care in accordance with state laws and regulations as well as federal laws and regulations.²³⁸ Some of the punishments for failing to comply with these regulations include revocation of the facility’s license and large fines.²³⁹ In addition, Medicaid and Medicare each have their own regulations and penalties, and violations of these regulations may result in revocation of provider agreements, reimbursement dollars paid to the facilities, and even the operator’s license to do business.²⁴⁰ These regulations are supposedly set in place to hold long-term care facilities accountable, yet attorneys heavily rely on violations already noted and enforced by regulatory agencies.²⁴¹ For one specific action, the facility may receive a survey violation and face an elder abuse lawsuit.²⁴² This appears duplicitous. Additionally, even if current elder abuse statutes did not exist, plaintiffs could still sue under federal criminal abuse and neglect laws as well as under state tort law.²⁴³ Consequently, the scope and definition provided for “abuse” under

236. *Id.* (quoting Dr. Steven Reznick).

237. UNIV. OF MINN. SCH. OF PUB. HEALTH, STATE OPERATIONS MANUAL: CHAPTER 7—SURVEY AND ENFORCEMENT PROCESS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES 13 (Aug. 10, 2010), http://www.hpm.umn.edu/NHRegsPlus/Resources%20and%20Publications/CMS_Survey_Resources/CMS/Ch07_som107.pdf (“The nursing home reform regulation establishes several expectations. The first is that providers remain in substantial compliance with Medicare/Medicaid program requirements as well as State law.”).

238. *Basics*, *supra* note 217 (explaining the various ways that states address elder abuse).

239. *Who Regulates Nursing Homes?*, ILL. DEP’T PUB. HEALTH, <http://www.idph.state.il.us/healthca/nhregulate.htm> (last visited Nov. 23, 2015).

240. *Id.*

241. *See, e.g.*, Gil Smart, *Law Firm Targets Nursing Homes*, LANCASTERONLINE.COM (Mar. 13, 2011), http://lancasteronline.com/news/law-firm-targets-nursing-homes/article_5924cecf-c01c-581b-bb59-3e1d88377d9b.html?mode=jqm.

242. *Id.* “Survey reports and deficiencies can become evidence in malpractice suits, and recent cases have resulted in significant awards against homes.” U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., STATE PROGRESS IN CARRYING OUT THE NURSING HOME SURVEY REFORMS 7 (May 1993), <http://oig.hhs.gov/oei/reports/oei-01-91-01580.pdf>.

243. “A state’s basic criminal laws also can be used to prosecute perpetrators of abusive actions against elderly people. . . . Civil and criminal actions against abusers may also deter victimization of the vulnerable.” AARP POLICY BOOK 2009–2010, at 12-3, http://assets.aarp.org/www.aarp.org/_articles/legpolicy/2008/Chapter12.pdf.

state elder abuse statutes impacts the likelihood of whether nursing homes will be sued.

Even in states with tort reform, elder abuse statutes may still cause disparity among doctors and facilities in different states. For example, California has some of the strongest tort reform measures in place, which limit damages and deter attorneys from filing tort claims in that state.²⁴⁴ However, California also has one of the most comprehensive elder abuse laws, which impacts individual physicians.²⁴⁵ One of the main components of California's elder abuse law is the need to report suspected abuse of anyone over age sixty-five; failure to do so results in a misdemeanor charge for the person who failed to report.²⁴⁶ This provision causes doctors to report "abuse" in situations that are not necessarily abusive (based on the definition provided).²⁴⁷ For example, a husband took "superbly good care" of his wife according to their doctor,²⁴⁸ yet the doctor had to explain to the husband that although the doctor did not believe that the husband abused his wife, if she were to fall, the doctor could be held liable for not reporting suspected elder abuse on the husband's behalf.²⁴⁹ Therefore, to protect himself from liability, the doctor filed a report on the husband despite having no evidence of a fall.²⁵⁰ This example illustrates how reporting laws may "antagonize [and cause a breakdown in] the physician-patient relationship" because doctors have needed to become increasingly adversarial to avoid liability.²⁵¹

In addition to reporting incidents of abuse, California physicians also risk being charged with committing elder abuse, which is a felony.²⁵² Although care facilities are most frequently charged with elder abuse, some individual physicians working at a long-term care facility fear it is not too far off in the future before elder abuse accusa-

244. Phyllis Maguire, *Why the Nation's Toughest Elder Abuse Laws Make Some California Physicians Nervous*, ACP INTERNIST (Mar. 2003), http://www.acpinternist.org/archives/2003/03/elder_abuse.htm.

245. *Id.*

246. *Id.* ("Physicians who ignore signs of abuse and fail to file a report can be slapped with a misdemeanor charge.")

247. *Id.* ("Sometimes, physicians say that reporting requirements have forced them to take an adversarial role with patients unnecessarily.")

248. *Id.* (quoting Dr. John A. LaFata, Fellow of the American College of Physicians).

249. *Id.*

250. Maguire, *supra* note 244. When the report was investigated, there was no evidence of abuse. *Id.*

251. *Id.* (quoting Dr. John A. LaFata, Fellow, the American College of Physicians).

252. *Id.* ("While physicians worry about abuse reporting, analysts say a much bigger threat is looming. Instead of facing a misdemeanor charge for not reporting abuse, some physicians may face charges of actually abusing seniors.")

tions start happening to them.²⁵³ Even though attorneys have been deterred by tort reform and the Medical Injury Compensation Reform Act of 1975 (MICRA),²⁵⁴ they have figured out that they can pressure doctors to settle even frivolous malpractice claims by simply threatening to sue for elder abuse²⁵⁵ because “[t]he mere threat of a felony elder abuse charge . . . often serves as a ‘hammer’ to force physicians to settle baseless claims.”²⁵⁶

In 2001, a landmark case resulted in a physician being held liable for elder abuse after allegedly failing to give a terminally ill patient adequate pain medication.²⁵⁷ This is one of the few cases in which an individual doctor was held liable despite not working in a long-term care facility.²⁵⁸ The deceased’s family members brought charges against the doctor even though neither the family nor the patient complained to the physician that the pain management was unsatisfactory.²⁵⁹ Nevertheless, the court found the doctor “liable for reckless elder abuse.”²⁶⁰ This outcome depicts how California’s elder abuse laws interact with tort reform protections.²⁶¹ Frank Randolph, a geriatrician in California, stated: “Attorneys are trying to ‘medicalize’ elder abuse”²⁶² Doctors are willing to settle cases because their malpractice insurance carrier will drop them if they are criminally charged.²⁶³ The fact that more attorneys are targeting nursing homes

253. *Id.* (“While attorneys may be focusing on nursing homes and long-term care facilities, the trend is already affecting individual physicians. The state’s supply of nursing home medical directors, for example, is being threatened.”).

254. CAL. CIV. CODE § 3333.2 (West 2015) (limiting damages to \$250,000 for noneconomic injuries due to professional negligence).

255. Maguire, *supra* note 244 (“Experts say that attorneys frustrated by the state’s caps on noneconomic damages have discovered that they can pressure physicians to settle even frivolous malpractice claims by threatening to bring elder abuse charges against them. If physicians don’t settle to avoid the charges and are found liable for elder abuse, medical malpractice protections no longer apply—allowing attorneys to pursue much larger awards and circumvent the state’s limits on malpractice settlements.”).

256. *Id.*

257. *Bergman v. Chen*, No. H205732-1 (Cal. Super. Ct. 2001); Maguire, *supra* note 244; *Doctor Liable for Not Giving Enough Pain Medication*, CNN.COM: L. CTR. (June 13, 2001, 12:28 AM), <http://www.cnn.com/2001/LAW/06/13/elderabuse.lawsuit/>.

258. Maguire, *supra* note 244 (“While this case made national headlines, it was one of only a few instances in which a doctor outside of a long-term care facility was charged with elder abuse. Most charges in California are brought against nursing homes, their administrators and the physicians who serve as medical directors.”).

259. *Id.* (“In addition, Mr. Slattery said that although complaints were made to the nursing staff, family members admitted that neither they nor the patient had complained to the physician that the patient’s pain was not being adequately addressed.”).

260. *Id.*

261. *Id.*

262. *Id.* (quoting Dr. Frank Randolph).

263. *Id.*

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also has an impact on the industry. “[M]ore physicians are simply unwilling to treat patients in long-term care” for fear of punitive elder abuse accusations.²⁶⁴

Although this Comment only uses California as an example, states across the country have begun creating elder abuse laws that are more punitive in nature to address the nationwide recognition of elder abuse and the issues surrounding it.²⁶⁵ And, as noted *supra*, the cause of protecting elders is easily prone to sympathy given that elders are family members and loved ones.²⁶⁶ But, the implications on doctors and nursing homes who deal with almost entirely elderly patients can be burdensome on an industry that is in great need of protection.²⁶⁷

California’s elder abuse laws are very punitive in nature, which may not be the best solution despite elder advocates’ arguments that it is better to be “too careful” than not careful enough²⁶⁸ and that it is more beneficial to incentivize fear than for doctors to think they can get away with anything. But, in the long run, it is important to consider how these implications will impact the health care system generally and, specifically, how they will negatively impact the quality of care elders receive.

D. A Model Federal Elder Abuse Statute

The federal government should establish a model definition of elder abuse for the states to adopt because it will clarify what actions constitute abuse and provide a national standard to ensure equality among the states. This definition should focus on intentional acts instead of unintentional or negligent acts, which would put the focus back on “true” abusive actions. Because negligence definitions already cover the failure to act, the “abuse” definition should focus on actual abusive actions toward an elderly individual. For example, similar to a modified version of the Kentucky elder abuse statute, the model federal elder abuse statute should define abuse as: “the (1) [intentional]

264. Maguire, *supra* note 244.

265. *Id.* (“And while California may be a long way from where you practice, states across the country are passing tougher elder abuse statutes—meaning that physicians everywhere may soon be vulnerable to similar tactics.”).

266. *See supra* note 5 and accompanying text.

267. *See* Stevenson & Studdart, *supra* note 7, at 226.

268. *See, e.g., Elder Abuse: Indicators and Examples*, 5 MARQ. ELDER’S ADVISOR 106 (2003) (“A careful balance must be found between being too cautious and not being cautious enough. Excessive caution can hurt or embarrass someone, while not enough caution can be dangerous or deadly.”). “But the real brushfire is the quiet revolution of caps on non-economic and punitive damages that is altering the legal environment in favor of the nursing home industry.” Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 391 (2006).

infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury.”²⁶⁹ In addition to this definition of abuse, negligence claims could still be brought under “negligence” definitions.

Changing the definition is merely the first step; the issue still remains regarding how nursing homes can prevent the onslaught of claims against their institutions when attorneys sue for various causes of action (including medical malpractice and elder abuse). However, ensuring that the “elder abuse” definition is clear, concise, and incorporates intentional acts of abuse will hopefully reduce duplicative elder abuse cases against nursing homes.

1. *A Call on Congress’s Spending Powers To Incentivize Uniformity*

The question then becomes how to make this uniform definition come to fruition. One possible mechanism would be to call on Congress to create a federal definition and subsequently incentivize the states to adopt that definition. Congress is not able to directly impose a mandatory definition onto the states because the Tenth Amendment prohibits federal intervention when the states have sovereignty.²⁷⁰ More specifically, the Tenth Amendment states: “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”²⁷¹ However, as evidenced in *South Dakota v. Dole*,²⁷² Congress does have power to indirectly encourage states to create uniformity by attaching conditions on the receipt of federal funds.²⁷³

In *Dole*, Congress desired for all states to raise the drinking age to twenty-one in an effort to increase interstate driving safety.²⁷⁴ Because Congress could not directly impose a minimum drinking age law on the states, it used its spending powers to attach conditions to the receipt of federal highway funds that otherwise would have been granted to the states.²⁷⁵ Under the Spending Clause, Congress has the power to “lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States.”²⁷⁶ Incident to this power is the ability “to fur-

269. KY. REV. STAT. ANN. § 209.020 (LexisNexis 2013).

270. See, e.g., *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

271. U.S. CONST. amend. X.

272. 483 U.S. 203.

273. *Id.* at 206.

274. *Id.* at 205.

275. *Id.*

276. U.S. CONST. art. I, § 8, cl. 1.

ther broad policy objectives by conditioning receipt of federal moneys upon compliance by the recipient with federal statutory and administrative directives.”²⁷⁷ However, there are three limitations on Congress’s spending power: (1) “exercise of spending power must be in pursuit of ‘the general welfare’” (in which a strong deference is given to the judgment of Congress);²⁷⁸ (2) the condition of “receipt of federal funds . . . must [be done] ‘unambiguously’” so that the states knowingly make the decision;²⁷⁹ and (3) conditions on grants must be related to a “federal interest in particular national projects or programs.”²⁸⁰ In addition, Congress’s actions must not be coercive so that “pressure turns into compulsion.”²⁸¹ For example, if South Dakota refused to adopt the twenty-one minimum drinking age law, only 5% of the state’s highway funds would have been withheld.²⁸² Therefore, the *Dole* Court held that Congress was not being coercive by incentivizing the state.²⁸³ In *Dole*, Congress “offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose[.]” which was a valid use of the spending power.²⁸⁴

To incentivize the states to adopt the uniform definition of elder abuse, Congress should adopt a similar approach to *Dole*. For example, Congress could withhold certain health care funds that are not directly related patient care to go toward program development or administration. Or, the OAA,²⁸⁵ which is a federal program that provides grants to the states for “community planning and social services, research and development projects, and personnel training in the field of aging[.]”²⁸⁶ could withhold a small portion of funds for a state that chooses to have a different definition of elder abuse. This would prevent Congress from punishing patients who receive direct care but still give states a push to ensure that they are receiving all possible health

277. *Dole*, 483 U.S. at 206 (quoting *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980)).

278. *Id.* at 207.

279. *Id.* (quoting *Pennhurst State Sch. & Hospital v. Halderman*, 451 U.S. 1, 17 (1981)).

280. *Id.* (quoting *Massachusetts v. United States*, 435 U.S. 444, 461 (1978)).

281. *Id.* at 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

282. *Id.*

283. *Dole*, 483 U.S. at 211–12.

284. *Id.*

285. Pub. L. No. 89-73, 79 Stat. 218 (codified as amended in scattered sections of 42 U.S.C.).

286. *Older Americans Act*, ADMIN. ON AGING, U.S. DEP’T HEALTH & HUMAN SERVS., http://www.aoa.gov/AoA_programs/OAA/.

care and aging services. As stated *supra*, states will need funding for these services more than ever in the coming years.²⁸⁷

This proposition is plausible for several reasons. First, it would be in pursuit of the general welfare. The definition of elder abuse is fractured among the states, which halts research, harms statistics, and inhibits the federal government from adequately putting protective measures in place for elders. In addition, it indirectly causes harm to long-term care facilities that are subject to varying definitions in different states. Second, the process could be done unambiguously so that states would clearly understand the consequences of their decisions. Third, it is related to federal programs and projects as evidenced by the Older Americans Act, Elder Justice Act, and other aging programs in which the federal government has involved itself.²⁸⁸ Lastly, it is not coercive because only a small percentage of funds would be withheld.²⁸⁹

2. *Other Less Aggressive Options for Implementing Uniformity*

Another less controversial solution would be for the federal government create a definition of elder abuse and incentivize states to adopt this definition as a form of “best practice.” States that implement this definition would be in compliance with best practice standards, which would mean that they are following practices superior to most and receive recognition by being put on a certain registry or list of best practicing states. This would neither cost the federal government any additional money nor would it take away money from valuable causes.

Yet another proposition would be for the OAA, or another aging services organization, to provide a grant to encourage states to comply with the federal definition. The OAA could provide a grant so that professional and legal members of the community could come together to form a definition that aligns with the federal government’s suggestions. Because planning projects cost money and time, the OAA’s grant could excite states to become involved in this issue.

These are just a few of the mechanisms that could be used for implementing a model elder abuse definition. This standard definition still protects vulnerable elders from “true” intentional abusive actions

287. See U.S. DEP’T OF HEALTH & HUMAN SERVS., LONG-TERM CARE FOR THE BOOMERS: A PUBLIC POLICY CHALLENGE FOR THE TWENTY-FIRST CENTURY 10–11 (1991), <http://aspe.hhs.gov/daltcp/reports/boomers.pdf>.

288. See generally *supra* notes 84–125 and accompanying text (discussing legislative actions that improved the nursing home industry).

289. See generally *supra* notes 270–88 and accompanying text (discussing Congress’s power to discuss receipt of federal funds).

against them; however, it would protect nursing homes against lawsuits for unintentional actions, such as “slip and falls,” that are often lumped together and disguised as intentional abuse under some current state elder abuse laws.²⁹⁰ This coordinated approach to defining elder abuse would reduce the burden in an already overburdened system.²⁹¹ Currently, both sides seem to be losing because quality still remains an issue, and litigation as well as its costs continue to soar.

IV. IMPACT

Creating a uniform definition for elder abuse will likely have a positive impact on the legal community, nursing home industry, and society at large. The standardization of elder abuse will help to: (1) streamline information and generate more accurate elder abuse statistics; (2) reduce state forum shopping and ultimately decrease predatory litigation among the states; (3) provide a clearer, more definitive understanding of abuse so that health care facilities understand liability; (4) promote quality of care by putting the focus back on patient-centered care and off of litigation costs; and (5) build up the nursing home industry in a time when it is crucial to the population.²⁹²

A. *A Standardized Definition Will Allow for Better Information Collection*

There is a reason that the number of elders abused or neglected is unknown in the United States: there are no official, collective federal statistics.²⁹³ This lack of information forces U.S. leaders to rely on estimations.²⁹⁴ The National Center on Elder Abuse (NCEA) states three main reasons for the absence of elder abuse statistics: (1) the definition of elder abuse differs among the states; (2) a uniform reporting system is lacking; and (3) no national data is being collected.²⁹⁵ Creating a uniform model definition of elder abuse is the first step to solving this issue because it will be easier to collect national information through a reporting system once the definition is the same among all states. This will allow the government, both on the state and federal levels, to implement better policies, regulations, and laws to combat abuse in the elderly community because the gov-

290. See *supra* notes 158–75 and accompanying text, for examples of states that lump abuse and negligence together.

291. See Studdert et al., *supra* note 14, at 1247–49.

292. See *infra* notes 293, 308, and accompanying text.

293. NAT'L CTR. ON ELDER ABUSE, *supra* note 225.

294. *Id.*

295. *Id.*

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ernment will be able to focus on one definition instead of interpreting different definitions in each state. Without true and accurate numbers to guide community leaders, research and improvement will continue to lag.

B. Standardizing Elder Abuse Will Reduce Forum Shopping Among the States

Plaintiffs’ attorneys tend to flock to states with little tort reform, broad definitions of elder abuse, and broad discovery rules.²⁹⁶ This puts nursing home facilities and other health care professionals in those states at a higher risk of being sued.²⁹⁷ In addition, it turns attorneys away from, and makes litigation more difficult in, other states in which elders still need assistance.²⁹⁸ Creating a uniform federal definition for elder abuse puts all states at a level playing field. Moreover, it would prevent predatory litigation from out-of-state firms that attempt to target and exploit a state for its lenient laws.²⁹⁹

C. A Clear Definition Would Take Away Unfair Standards for Health Care Professionals

As discussed *supra*, a doctor in a hospital is judged under the same standard for medical negligence as a doctor in a nursing home, yet a doctor in a nursing home may face the additional risk of being accused of elder abuse.³⁰⁰ This is because some elder abuse definitions incorporate negligence into their definitions.³⁰¹ Therefore, while a doctor in a hospital could be sued for medical negligence, another doctor at a nursing home could be sued for that same negligent act under a state elder abuse statute that tends to be more punitive.³⁰² It seems unacceptable that doctors in both settings would be judged based on the same standard, what “a reasonable, similarly situated professional

296. See AON RISK SOLUTIONS, *supra* note 126, at 5; Stevenson & Studdert, *supra* note 7, 226–27.

297. See AON RISK SOLUTIONS, *supra* note 126, at 5.

298. See *supra* notes 185–206 and accompanying text (arguing that these jurisdictions are less economically attractive).

299. See *generally supra* notes 16–19 and accompanying text (noting that litigation trends vary depending on the definition of elder abuse).

300. See *supra* notes 230–36 and accompanying text. “The first element is that a legal duty existed toward the patient; this duty comes into play whenever a professional relationship is established between the patient and health care provider.” B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS & RELATED RES., 339, 342 (2009).

301. See, e.g., ARIZ. REV. STAT. ANN. § 46-451 (2014).

302. Bal, *supra* note 300, at 342 (the standard for medical malpractice).

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would have provided to the patient,”³⁰³ yet are punished under two different statutes. This lack of consistency is concerning for the health care profession, especially when the need for doctors in long-term care settings is at an all-time high.³⁰⁴ It is important that all doctors are held to the same standards, and a uniform definition of elder abuse should be a first step in the process.

D. Shifting the Focus away from Litigation and back to Patient-Centered Care

One of the uniform statute’s main goals would be reducing litigation costs so that instead of spending money on litigation, nursing home facilities could focus on providing patients with quality care. Nursing homes are largely federally funded, and they have received substantial budget cuts in recent years.³⁰⁵ Litigation costs are harming an industry that already faces financial repercussions. The cost of litigation is not necessarily improving quality of care like proponents claim,³⁰⁶ in fact, it may actually be reducing quality because funds are not be appropriately utilized.³⁰⁷ As evidenced in a *New England Journal of Medicine* study, nursing homes with the best quality ratings are sued only marginally less than the worst rated facilities.³⁰⁸ This shows that litigators may be focusing on the nursing home industry as a whole rather than advocating for specific individuals. Litigation is still a critical tool that should be utilized against long-term care facilities for abusive actions against residents; however, reducing predatory litigation is necessary to safeguard the industry that determines the quality of care and life for these elders.

E. Building Up a Critical Industry

At a time when the population is booming with elders, protecting and promoting industries that serve this population is more imperative

303. *Id.*

304. Maguire, *supra* note 244 (“[W]ho will care for the very vulnerable elderly patients if the risk of elder abuse allegations keeps scaring physicians away from the field[?]”).

305. Smith, *supra* note 10.

306. Stevenson & Studdert, *supra* note 7, at 225 (discussing the opinion of consumer advocates and the plaintiffs’ bar).

307. Jennifer Goodwin, *Lawsuits Aren’t Improving Nursing Home Care: Study*, U.S. NEWS (Mar. 30, 2011, 5:00 PM), <http://health.usnews.com/health-news/family-health/boomer-health/articles/2011/03/30/lawsuits-arent-improving-nursing-home-care-study?page=2> (“These legal distractions demoralize providers and employees, threaten staffing ratios and most importantly diminish resources from facilities providing good quality of care . . .” (quoting Teresa Cagnolatti, Director of Government Relations, American Health Care Association)).

308. Studdert et al., *supra* note 14, at 1248.

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than ever before.³⁰⁹ “Elder abuse is everyone’s issue.”³¹⁰ Nursing homes are becoming more important than ever before, and it is time to take a stance for these facilities.³¹¹ Creating a clear definition of elder abuse is one way to help protect this industry while still providing protections for the elderly population.

V. CONCLUSION

Protecting elders should be a top priority in the United States because incidents of elder abuse have risen and will likely continue to rise in the years ahead. The goal is for nursing homes to be efficient and safe while still providing the best quality care available to their residents.

Reducing predatory and duplicitous litigation among states with varying definitions of elder abuse is one step in the process. Elder abuse should be clearly defined at the federal level so litigators have no reason to forum shop among the states for a state with lenient elder abuse laws that promote nursing home litigation. Although individuals have the right to sue nursing home facilities for wrongful conduct, exploiting nursing homes in favorable legal climates is not protecting elders. The varying elder abuse statutes are not doing their job in reducing elder abuse claims overall; it is time for a shift in focus and for the federal government to implement a uniform definition of elder abuse. We cannot protect elders if we do not protect the facilities that care for them.

*Meagan Pagels**

309. Kroll, *supra* note 23, at 403–04 (“The momentum of aging within the older population propelled by the baby boomers will be significant.”).

310. Wrosch, *supra* note 52, at 1.

311. “In the coming decades, the sheer number of aging baby boomers will swell the number of elderly with disabilities and the need for services.” *Long-Term Care Testimony*, *supra* note 26, at 10 (statement of David M. Walker, U.S. Comptroller General).

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