PHCA Convention &
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Sexuality & Dementia: Avoiding Legal Pitfalls

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Sexuality & Cognitively Impaired Residents

- Can a resident with dementia consent to sexual intimacy with another?
- What if the resident mistakenly believes another resident is her/his spouse?
- What are the rights of the resident(s)?
- What are the obligations of the facility?
- How can facilities mitigate, if not eliminate risks of liability while respecting resident rights?

Two Recent Cases Illustrate the Problem for SNFs

- *State of Iowa v. Henry Rayhons*
- Windmill Manor Nursing Home, Coralville, Iowa
  - *In the Matter of Steve Drobot, NHA*
  - *In the Matter of Karen Etter, DON*

State of Iowa v. Henry Rayhons

- May 15, 2014 Care Plan Meeting – SNF informs Mr. Rayhons that his wife "did not have the cognitive ability to consent to sexual activity." (Wife had dementia.)
- May 23, 2014 Roommate complains that she heard noises indicative of sexual activity between Mr. & Mrs. Rayhons.
- Camera records Mr. Rayhons placing wife's undergarments in hamper
- SNF contacts law enforcement (DNA match – semen/quilt)
- Mr. Rayhons admits to sexual intercourse with wife
- Mr. Rayhons charged with "Sexual Abuse in the 3rd Degree" (Class C Felony).
- Not guilty verdict (May 2015)

Windmill Manor Nursing Home

- MR - 78 y/o former college professor
- FR - 87 y/o retired secretary
- Both MR & FR had dementia

- November 17, 2009 Incident
  - MR & FR in bed together (both naked from waist down)
- December 25, 2009 Incident
  - Residents found having intercourse

Windmill Manor Nursing Home

- DON informed of possible sexual abuse between 2 residents in dementia unit
- Late entry in nurses' notes falsely stating exam conducted on female resident
- DON instructed staff to chart inaccurate note following allegation of sexual abuse (same two residents)

Windmill Manor Nursing Home

- DON charged with: "unethical conduct" "failure to assure that nursing care provided under her supervision was adequate and delivered appropriately," "failing to assess, accurately document, or report the status of a patient" and "committing an act which caused physical, emotional injury to the patient."
- NHA charged with: 1) Professional incompetence; 2) Negligence; 3) Violation of a regulation.

Aftermath: Windmill Manor Nursing Home

- DON fired
  - "It ruined my life."
- NHA fired
  - "It's the most difficult thing I've ever had to live through."
- State survey agency claims "sexual assault"
- CMP issued
- Male resident (MR) discharged (2 hours from family)
- Female resident's family sues nursing home
- Negative publicity for nursing home, others
- Complete lose-lose situation

Source: Bloomberg News, *Boomer Sex With Dementia Foreshadowed in Nursing Home*, July 22, 2013

State Operations Manual

- Interpretive Guidelines §483.10(a)(1)
- Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

State Operations Manual

"Whenever there appears to be a conflict between a resident's right and the resident's health or safety, determine if the facility attempted to accommodate both the exercise of the resident's rights and the resident's health, including exploration of care alternatives through a thorough care planning process in which the resident may participate."

CMS Interpretive Guidelines § 483.10(d)(3)

Statutory Authority

- "As the [Social Security] Act provides, a resident is to receive services with reasonable accommodation of individual needs and preferences 'except where the health or safety of the individual or other residents would be endangered . . . .' Act § 1819(c)(1)(A)(v)(I)."
- *Azalea Court v. CMS*, CR2134 (2010)

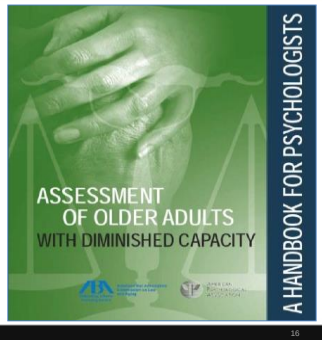
Sexual Intimacy & Dementia

- Resident - resident (includes same-sex couples)
- Resident - employee
- Resident - former employee
- Resident - spouse
- Resident - non-spouse
- Practice tip: Ongoing documented evaluation of capacity to consent is critical.

Normal vs. Abnormal Sexual Behavior

- Obtaining adequate history of present illness
  - What is context, how frequent?
  - Is it a problem? For whom?
  - Other medical history
  - Attention seeking behavior?
  - Could this be normal? Something else explain the behavior? Is it being misinterpreted?
- Sexual activity/impulses/behavior can be normal
  - Often more biologic/emotional than intellectual
  - Normal behavior often misinterpreted as abnormal

Determining Decision-Making Capacity (DMC)



Sexual Consent Capacity

16 not if, but how.

P. Lichtenberg: Questions to Assess Sexual Consent Capacity (cited in ABA/APA Handbook, p. 67)

1. Resident's awareness of relationship
   a. Is the resident aware of who is initiating sexual contact?
   b. Does the resident believe the other person is a spouse and, thus, acquiesces out of a delusional belief, or is he/she cognizant of the other's identity and intent?
   c. Can the patient state what level of sexual intimacy she/he would be comfortable with?
2. Resident's ability to avoid exploitation
   a. Is the behavior consistent with formerly held beliefs/values?
   b. Does the resident have the capacity to say "no" to uninvited sexual contact?
3. Resident's awareness of potential risks
   a. Does the resident realize that this relationship may be time limited?
   b. Can the resident describe how he/she will react when the relationship ends?

17 not if, but how.

Determining Competency and Capacity

- Competency is a legal determination
- Capacity is a clinical determination
- Both may be transient
- Practice tip: Decision-making capacity may wax and wane; it is not necessarily static and neither should the assessment be.

18 not if, but how.

Capacity for Sexual Consent

- No universally accepted criteria for capacity to consent to sexual activity
- Legal standards and criteria vary across states
- No legal standard for the assessment process
- No specific assessment tools for assessment

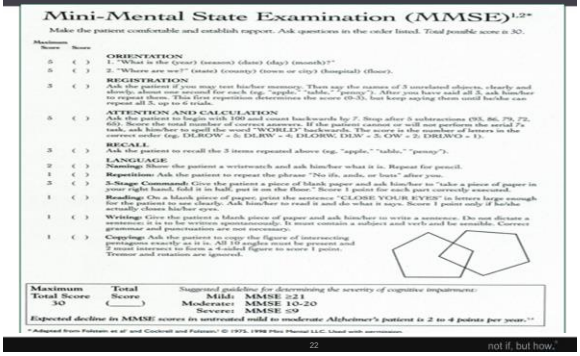
Capacity for Sexual Consent Consultation

- Generally Includes:
  - Evaluation of psychosocial history
  - Review of medical and psychiatric records
  - Clinical interview & behavioral observations
  - Medication review
  - Functional capacity assessment
  - Cognitive & mood assessment
  - Collateral interviews
  - Other information as deemed necessary
    - Refined skills in use of neuropsychological assessment instruments

Salient Assessment Factors

- Time of day, place of assessment
  - Stimulus free environment; no 3rd party observers
- Is resident rested and sufficiently able to participate in assessment?
  - (hearing/vision/language intact?)
- Clinician objectivity
- Standardized testing procedures
- Attention to cultural issues
  - Assessment in primary language?
  - Is interpreter needed?

MMSE



Mini-Mental State Examination (MMSE)[1,2]*

Make the patient comfortable and establish rapport. Ask questions in the order listed. *Total possible score is 30.*

Maximum Score	Score	
5	( )	**ORIENTATION** 1. "What is the (year) (season) (date) (day) (month)?"
5	( )	2. "Where are we?" (state) (county) (town or city) (hospital) (floor).
3	( )	**REGISTRATION** Ask the patient if you may test his/her memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each (eg, "apple," "table," "penny"). After you have said all 3, ask him/her to repeat them. The first repetition determines the score (0-3), but keep saying them until he/she can repeat all 3, up to 6 trials.
5	( )	**ATTENTION AND CALCULATION** Ask the patient to begin with 100 and count backwards by 7. Stop after 5 subtractions (93, 86, 79, 72, 65). Score the total number of correct answers. If the patient cannot or will not perform the serial 7's task, ask him/her to spell the word "WORLD" backwards. The score is the number of letters in the correct order (eg, DLROW = 5; DLRW = 4; DLORW, DLW = 3; OW = 2; DRLWO = 1).
3	( )	**RECALL** Ask the patient to recall the 3 items repeated above (eg, "apple," "table," "penny").
2	( )	**LANGUAGE** **Naming:** Show the patient a wristwatch and ask him/her what it is. Repeat for pencil.
1	( )	**Repetition:** Ask the patient to repeat the phrase "No ifs, ands, or buts" after you.
3	( )	**3-Stage Command:** Give the patient a piece of blank paper and ask him/her to "take a piece of paper in your right hand, fold it in half, put it on the floor." Score 1 point for each part correctly executed.
1	( )	**Reading:** On a blank piece of paper, print the sentence "CLOSE YOUR EYES" in letters large enough for the patient to see clearly. Ask him/her to read it and do what it says. Score 1 point only if he/she actually closes his/her eyes.
1	( )	**Writing:** Give the patient a blank piece of paper and ask him/her to write a sentence. Do not dictate a sentence. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.
1	( )	**Copying:** Ask the patient to copy the figure of intersecting pentagons exactly as it is. All 10 angles must be present and 2 must intersect to form a 4-sided figure to score 1 point. Tremor and rotation are ignored.

Maximum Total Score	Total Score	Suggested guideline for determining the severity of cognitive impairment:
30	(____)	Mild: MMSE ≥21 Moderate: MMSE 10-20 Severe: MMSE ≤9

Expected decline in MMSE scores in untreated mild to moderate Alzheimer's patient is 2 to 4 points per year.[3]

The Right to Adequate Protection from Unconsented-to Sexual Aggression in LTC

- Survey of 300 NHs in 3 states: **17-25% of NH residents had unpleasant experiences from hypersexual behavior of other residents**; 20-30% of these required staff intervention (1)
- 60-67% of victims of elder sexual abuse have dementia (2)
- 3-7% of NHs house an identified sex offender (3)

1. Holmes D et al. Int J Ger Psych 1997;12:695-701. Cited in Rosen et al. JAGS 2010;58:1070-1079.
2. Ramsey-Klawsnik et al. J Elder Abuse and Neglect 2008;20:353-376. Burgess et al. JAGS 2006;54:1154-1155. Cited in Rosen, et al.
3. Corson TR, Nadash P. JAMDA 2013;14:787-790.

Challenges to Authentic Sexual Consent in Dementia

- **No universal definition of capacity** for sexual consent in dementia
- **No standardized tool for assessing capacity** for sexual consent in dementia
- **Cultural diversity** concerning sexual ethics
- **Lack of knowledge, ageist bias** re: older adult intimacy in LTC
- Potential tension between **resident privacy** and **role of family**
- **What is at stake: Is it consensual sexual activity, is it inappropriate sexual behavior, is it abuse, or is it rape?**
- **Resident rights vs. resident safety conundrum**

LTC Ombudsmen's Perspectives on Sexual Consent in Dementia (31 Ombudsmen in 6 states)

- Issues: risks; limited knowledge; lack of privacy; conflicts of values
- Conflicts between freedoms, rights and protection
- Support and education for spouse as well as resident

"Medical history and records, personal interviews, involvement of other medical professionals and psychiatrists, and substitute decision makers such as family members or medical powers of attorneys were all used to assess capacity."

"An ombudsman's goal is to consider the situation from the resident's perspective and advocate for their best interests. This is difficult to achieve when the issue of consent is ambiguous."

Cornelison and Doll. *The Gerontologist* 2012;53(5):780-789.

Perspectives of Family Members with Loved Ones in LTC on Sexual Consent in Dementia

"Residents can go so far, but not all the way"
- Families want residents to have happiness and quality of life
- Mixed opinions on capacity to consent to intercourse in dementia

"It's difficult for the staff to cope"
- Families are sympathetic to the dilemmas faced by nursing staff
- Perceived lack of training, lack of time, and legal jeopardy for staff

"We need to know what's going on"
- Families are consistently adamant that they should be informed
- Some assert it is their legal right
- Some cite the pain of being surprised when they find out

Bauer et al. Dementia 2014;13:571-585

LTC Sexuality Policies

- 2013 AMDA Sexuality survey
  - N = 175, mostly CMDs
    - 30% Formal training re intimacy/sexuality in LTC
    - 23% Institutional policies
    - 13% Staff training
- 2015 national survey re: sexual activity in LTC
  - N = 366 Directors of Nursing
  - Total Policies – 135
    - Written policies – **78**
    - Policies are not uniform

Bach & Meyers (2013). AMDA. Lester, et al. (2016). Sex in Nsg Homes: Policies Governing Sexual Activity. JAMDA. 17: 71-74.

Tips for Policies and Procedures

- Create & disseminate clearly written P & P
  - Include on web site & in marketing materials
- Educate administrators, providers, staff, residents, families
- Provide ongoing in-service education for staff
- Reinforce sensitivity training & support for policy implementation
- Include policies in admission package to resident & family.
- Optimize communication among all stakeholders

Policies & Procedures

POLICIES AND PROCEDURES
CONCERNING SEXUAL EXPRESSION
AT THE
HEBREW HOME AT RIVERDALE

Updated by

Robin Dessel, LMSW
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The Hebrew Home at Riverdale
Riverdale, New York
August 1995
May 2001 (revised)
April 2013 (revised)

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What can a Facility do to minimize, if not eliminate liability?

- The first step is recognizing the potential problems
- Learn from others' mistakes (Lessons Learned)
- Be proactive
- Continue to evaluate your approach, revise PRN

Recommendations

- Recognize the issues concerning sexual activity and residents with dementia
- Educate staff (resident rights-resident safety)
- Develop appropriate policies and procedures
- Understand that decision-making capacity (DMC) may wax and wane
- Assessments must be fluid, not static (MMSE, BIMS)
- Care Plan accordingly
- Involve IDT
- Involve all appropriate stakeholders (LTC Ombudsman, religious leaders, family, medical director/attending, psychiatrist, social worker, other)

Recommendations

- Document all pertinent information (assessments, discussions, care plan, etc.)
- Engage QAPI Committee
- Involve Facility's Ethics Committee (If available)
- Seek input from LTC Ombudsman
- Ensure that attending and psychologist or psychiatrist have made a clinical determination regarding resident's ability to consent to intimacy whenever DMC may be an issue
- Consider offering residents the opportunity to address wishes in an advance directive
- Consult legal counsel as appropriate

Resources

- AMDA Clinical Practice Guide (CPG) *Decision-making capacity (DMC)*
- Alzheimer's Association
- *Policies & Procedures Concerning Sexual Expression at the Hebrew Home at Riverdale*
- CMS SOM - Resident Rights, Accommodation, Freedom of Choice
- *Sexuality and Long-Term Care: Understanding and Supporting the Needs of Older Adults*, Prof. Gayle Appel Doll
- AMDA Policy: Clin.CLI.13: *Privacy and Sexuality*
- ABA/APA Publication*, Assessment of Older Adults with*
- *Diminished Capacity: A Handbook for Lawyers*