Law Enforcement Training Course

Training Unit

RESPONSE TO ALLEGATIONS OF CRIMINAL ACTIVITY BY NURSING HOME PATIENTS

Instructor's Guide

Developed by the
Maryland Police and Correctional
Training Commissions

NOTICE

Due to the dynamic nature of law enforcement and the impact of court decisions and statutory changes on police and correctional operations, it is important that each department review this information to verify that it is consistent with current federal, state, and local law and regulations, and with departmental policy and procedure. This information is not intended to substitute for the advice of legal counsel. You should speak with your legal advisor about the sufficiency of your department's manual, policy, curriculum, and training program. This material should not be used as the sole basis for compliance with any law or regulation, and departments should not rely on this material as a legal defense in any civil or criminal action. The Police & Correctional Training Commissions have compiled and distributed this information as a guide for the individual departments, and are not responsible for the content and delivery of this material by other departments.

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INTRODUCTION

This training unit was developed as a supplement for Maryland law enforcement training. It is particularly suited for roll call training and in-service training sessions. The primary-preferred audience is first-responding patrol officers and supervisors, and secondarily for criminal investigators.

In a roll call training format, it is recommended that this training unit can be delivered in five 10-minute sessions immediately following roll call. This unit is comprised of six sections, five of which are actual training materials, beginning with *Background* and ending with *Special Enforcement Considerations*. These five sections could be covered in a typical five-day work week.

For in-service training, it is recommended that one-hour of class time be devoted to covering this training unit. This one-hour training module would serve as an operational topic overview.

It would be very beneficial if this training would be delivered by one of your agency's certified instructors, rather than just being read-out across a roll call podium by a supervisor. The subject matter concerns a budding crime problem that most law enforcement agencies have little experience with to date, and will only worsen if ignored or treated in a casual manner.

Accordingly, this training material requires a conscientious and informed delivery by a competent instructor-facilitator. It would be advantageous if your designated instructor would research agency crime reports for any prior nursing home crime occurrences within your jurisdiction and was prepared to complement his or her training unit delivery with pertinent statistical and/or local background data.

The generic enforcement information in this training unit is only offered as <u>suggested</u> best-practices for Maryland law enforcement. Officers and supervisors are reminded that they should always strictly adhere to their parent agency's policies and procedures in this unique area of operations.

BACKGROUND

Nursing home crime is traditionally viewed as staff-on-patient offenses, in which elderly and infirm nursing home patients (or residents) are abused or criminally neglected by nursing home employees.

Another lesser aspect is patient-on-patient crime in which nursing home patients commit criminal acts on other patients. Typically, these incidents usually involve cognitively impaired individuals, invading another patient's personal space or eating from another's food tray.

In the past few years, however, a new phenomenon has surfaced in which a much younger population of nursing home residents in Maryland have become increasingly involved in criminal activities and behaviors that are disruptive to nursing home staff and other patients.

Mostly male, in the 20 to 55 years age group, these individuals are often victims of serious accidents often due to irresponsible behavior, sufferers of communicable illnesses, gunshot and violent crime victims, psychiatric patients and may even be confined to wheelchairs.

In many cases, they are discharged from local hospitals directly into nursing homes for continued convalescent treatment, ranging from just a few months to as much as several years. Many require special treatments and medication therapies, and most have complex and costly medical needs.

Their care and treatment in nursing homes is almost always covered by federal and state regulations with the accompanying onerous and complex bureaucratic requirements governing their care giving and maintenance. This younger nursing home population usually has negligible family support, often coming from disadvantaged and dysfunctional social/economic backgrounds.

Many of these individuals (but not all) often relapse into criminal activities and other undesirable behaviors while they are patients in these nursing homes, including, but not limited to the following conduct:

- Possession, use and distribution of CDS
- Sexual offenses and aggressive sexual behavior
- Possession and use of deadly weapons
- Assaults and threats on staff and other patients
- Bringing prostitutes into the nursing home facility
- Leaving the premises on authorized leaves and engaging in criminal acts in the surrounding community

SCOPE OF THE PROBLEM

A Dec. 10, 2003 *New York Times* article by reporter Patrick Healy revealed:

The nature of nursing home patients has changed dramatically in New York State and across the country. Today, many residents are in their 20's or middle-aged. Some have been homeless, others have come from prisons, and others have permanent disabilities from traumas like car accidents.

These patients bring with them problems that some health care advocates say are too complex and potentially dangerous for nursing homes to handle. Many (patients) have histories of drug abuse and mental illness, or complex medical problems…and can pose a threat to other residents or staff members who are often not trained to deal with such patients.

This assessment accurately sums up the situation that has been developing in Maryland nursing homes in the past decade. This surprising increase in younger patients in what was traditionally a haven for infirm, elderly patients who were unable to adequately care for themselves, has become a sobering reality for nursing home administrators and advocates nationwide.

The Health Facilities Association of Maryland, (HFAM) a nursing home trade organization, represents about 150 of the 260 licensed nursing homes in this State. HFAM has been prominent in addressing this on-going problem of crime in nursing homes and has effected liaison with the Maryland Police and Correctional Training Commissions (MPCTC) in an effort to:

- One, create an awareness among Maryland law enforcement agencies in the scope and extent of this problem, and;
- Two, recommend a series of operational "best practices" that Maryland law enforcement can use to effectively confront and combat this enforcement problem.

How bad is this problem? In June 2001, Deaton, a large nursing home in South Baltimore, affiliated with University Hospital, had to permanently close their 194-bed facility simply because the younger patient population they were required to accept from the host hospital and its Shock Trauma Center made daily operations unmanageable for the nursing home staff. Incidents of illegal drug activity, theft and aggressively violent behavior by this atypical, non-elderly patient population actually forced the voluntary closing and decertification of this large nursing home. [1]

RESPONDING TO COMPLAINTS

First responding patrol officers and supervisors should always remain alert to the potential for criminal activities and behavior problems that can be encountered

[1] Maryland Health Care Commission – Certificate of Need for the Closure of the Nursing Facility at University Specialty Hospital; March 19, 2004.

with younger patients in nursing homes. Don't treat these complaints lightly; it may not be simply another "routine" call-for-service.

Question: Well, you may ask, why doesn't the nursing home just kick these guys out if they're causing this much trouble?

Answer: Good question. These problem patients cannot simply be peremptorily tossed out on the street. For any patient to be removed or discharged from a nursing home, State and Federal law requires that they must instead be transferred to a "safe and secure locale," such as a residence, a shelter, a group home or another nursing home.

Also, understand that many of these younger nursing home patients are permitted to leave the nursing home premises under authorized leave policies. Predictably, they can and will become involved in criminal activities in the surrounding communities while on leave and they will just as conveniently use the nursing home as a virtual base for their illicit operations.

Question: Well, you may indignantly ask again, why do the nursing homes allow these guys to leave the premises and come and go as they please?

Answer: Another good question! If a nursing home patient requires a low level of care and is ambulatory, he or she may leave the premises on authorized leaves of absences, usually for short periods of time. This privilege is codified in the Nursing Home "Residents' Bill of Rights," (COMAR 10.07.09.00 *et seq*).

For all practical purposes, nursing homes are health care businesses and they rely on payments from medical insurance to support their operations, which involves the convalescence and treatment of disabled and incapacitated patients, some elderly and some not. Nursing homes play an important role in providing health care to younger patients with multiple medical problems and the majority of these younger patients do *not* engage in criminal activities.

Some of the calls-for-service to these facilities may not always require law enforcement intervention. They may be civil matters or they may merely involve minor violations of facility rules, such as consuming alcohol, verbal abuse, unauthorized smoking, and not necessarily criminal matters.

Similarly, officers may receive complaints of alleged criminal activities but will lack probable cause to effect an arrest. Again, officers should take the time to properly advise complainants how to obtain warrants or criminal summonses for the offender.

It is important that officers complete written reports on all calls-for-service to nursing homes, even if no enforcement actions were taken. It would be advantageous to document every nursing home call-for-service or on-view complaint with a field report to authenticate your agency's response to this problem.

In the event that a nursing home call-for-service would require an investigative effort beyond the parameters of patrol responsibility, officers and supervisors should make arrangements to refer the incident to their agency's criminal investigative specialists.

This approach would be particularly appropriate for allegations of illicit use and distribution of CDS, or any other organized criminal enterprise believed to be operating either within or emanating from a nursing home facility.

Between handling calls, it would be advantageous for patrol officers to visit nursing homes on their posts, speak to staff and, with management permission, occasionally walk thru the halls. The sight of a uniformed police officer in their midst can have a salutary effect on those nursing home patients with a propensity for bad behavior.

When responding to a call-for-service in a nursing home for an alleged criminal violation, even if you don't have probable cause for an arrest, always make it a point to interview the suspect(s). A face-to-face confrontation with a police officer will usually put the individual(s) on notice that the police are aware of their actions and that they are being viewed as criminal suspects.

Make it a point to speak to the nursing home administrator periodically. They may be able to supply information on criminal activities in the surrounding neighborhood, especially regarding locations where their patients may be obtaining drugs.

Important: A frequent complaint regarding this younger nursing home population is bringing CDS into the facility for use and sale, and theft from other patients. Officers should remain aware that a nursing patient's room can legally be considered his residence and that searches for drugs and stolen property or other contraband should be accompanied by a search warrant based on probable case and not merely on hearsay or speculation by nursing home staff.

BEST PRACTICES FOR LAW ENFORCEMENT

In view of this phenomenon of younger patients being diverted to local nursing homes, law enforcement officers should be increasingly sensitive to calls-for-service at nursing home facilities in their jurisdictions.

As a police officer, you have the same right to investigate a criminal complaint inside a nursing home as you would if you were properly summoned to a private residence or business. As long as you were permitted access by a responsible person affiliated with the nursing home, you may enter and conduct whatever reasonable inquiries you may deem necessary.

If you have sufficient probable cause to effect a warrantless arrest, you may do so in a nursing home regardless of the status of the suspect. This includes staff, patients and visitors.

On the other hand, you must obviously take into consideration the physical condition of the suspect. If the suspect is ambulatory, there will probably be few problems, other than ensuring that any required medications are available should the suspect be incarcerated, following booking and a preliminary hearing.

In the case of mobility-impaired suspects (usually wheelchair confined), they may still be taken into custody, provided that certain arrest and prisoner transport procedures are followed. Most law enforcement agencies have standing protocols for the arrest and transport of mobility-impaired arrestees.

The most extreme cases include mobility-impaired suspects who have feeding tubes or other intravenous (IV) apparatus attached. In these cases, officers should consult with supervisors to ensure that local holding/detention facilities are equipped to accept these kinds of prisoners, at least in the short-term.

Additionally, officers may want to consult with their local State's Attorneys' office before effecting the arrest of any seriously impaired suspect. Again, officers should always adhere to their agency's procedures for the arrest and custody of sick or physically-impaired arrestees.

In those cases where there is insufficient probable cause to effect an arrest, officers should always conduct a quality preliminary investigation. This may include spending sufficient time with the nursing home staff to:

- Identify any possible witnesses
- Recover any relevant physical evidence
- Secure and process any identifiable crime scenes
- Interview staff, visitors or other patients, including the suspect(s)

SPECIAL ENFORCEMENT CONSIDERATIONS

Arrestees in Wheelchairs:

You should handle the approach, interview, investigation, and arrest of a mobility impaired person in the same manner as you would anyone else. You should not allow your natural sympathy for a disabled person to prevail over your officer

safety instincts and training. Always bear in mind that a disabled person can hurt you just as badly as anyone else. **Focus on officer safety, not empathy**.

At the same time, remember that placing a person under arrest means that you are depriving them of their liberty to move about freely. As traumatic as this may be for any normal person, it is doubly distressing for a person with a mobility impairment because they have, in effect, already been deprived of a large measure of their freedom of movement because of their disability. They may, understandably, refuse to cooperate with any further infringement on their already-limited mobility. It is important to understand this frame of mind and be prepared to deal with it in a firm and understanding manner.

Best Practices:

When confronting a combative or confrontational wheelchair user, position yourself parallel to the rear-axle of the wheelchair, and on the control-box side of a motorized wheelchair.

Use the field interview stance approved by your agency and always maintain a safe reactionary gap. Keep your weapon-side away from the arrestee

Eliminate the chair as a weapon. Immobilize a wheelchair in the approved manner. Shut-off or disconnect the power on a motorized wheelchair and insert handcuffs or a baton between the wheel-spokes of a manual wheelchair.

Handcuff wheelchair-user arrestees to the frame of the wheelchair. Always double-lock handcuffs, and finger-test handcuffs for tightness. Handcuff crutches and cane-users after they are seated in the transport vehicle.

Search all mobility impaired arrestees incident to an arrest. If possible, have wheelchair users stand up if they are able.

Search the wheelchair and other assistive devices, along with any attached accessory bags or containers.

Transport mobility impaired prisoners according to your agency guidelines. Always inquire of nursing home staff (and arrestees) for any needed medications, verify drugs and dosage, and only dispense in strict accordance with your agency's policy.

Remain alert to any adverse physical or emotional stress reactions sustained by mobility-impaired arrestees

REMEMBER

A mobility-impaired person can be just as dangerous as any able-bodied individual, if not more so. Many wheelchair users have tremendous arm and

upper-body strength; they are just as capable of hurting you as an able-bodied person. Individuals in manually-operated wheelchairs have at least the same capability of users of electric-motorized chairs.

When handcuffing a wheelchair user, inquire if the individual has any physical problem that may be aggravated by handcuffing. It is usually advantageous to handcuff the person's wrists to the frame of the wheelchair after first making sure that the frame-section is not detachable. Obviously, you will need two sets of handcuffs or flex-cuffs.

Transporting an arrested wheelchair user can be problematic. Many law enforcement agencies have agreements with other agencies to use specially-modified vehicles, usually lift-equipped vans, to transport wheelchair arrestees. Most police agencies have policies and procedures in force that govern the transportation of an arrested wheelchair suspect to a booking/detention facility. Officers should be familiar with their agency's corresponding guidelines.

Arrestees With IV Feeding Tubes & IV Medications

The very best "policy" for suspects with IV tubes is to not take them into custody if you really don't have to. Obviously, law enforcement is not trained, conditioned or equipped to handle the medical needs of individuals with feeding tubes or IV drips attached.

An alternative solution would be to inquire of your county or municipality's detention facility and inquire if they can handle prisoners with these unique feeding and medication needs. In some cases, it may be necessary to refer custody to neighboring jurisdictions who have the necessary medical care available.

Again, most law enforcement and correctional agencies have policies in place for prisoners with these unique medical needs and officers should familiarize themselves with these proscribed procedures.