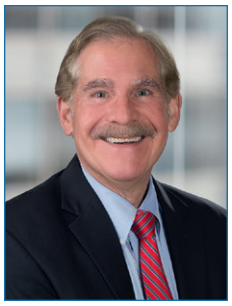

LEGAL ISSUES

By Alan C. Horowitz, Esq, RN

Sex and Dementia in the Nursing Home: Balancing Resident Rights with Resident Safety

Can a nursing home resident with dementia consent to being sexually intimate with others? It depends. The competing interests — respecting resident rights while protecting vulnerable residents from abuse — are nuanced and complex. As illustrated below, even expert physicians can disagree in a particular case.

State of Iowa v. Henry Rayhons

The criminal trial of Henry Rayons illustrates the pitfalls and enigmatic nature of the issue. Mr. Rayhons was well-respected in his community. He was repeatedly elected as an Iowa state representative from 1997 to 2015. He married his second wife, Donna, when both were in their 70s. Mrs. Rayons subsequently developed Alzheimer's disease, and in March 2014 she was admitted to a skilled nursing facility. She was assessed with the Brief Interview for Mental Status (BIMS) test, and in April and May 2014 scored a 2 and 0, respectively, out of a possible 15. (A BIMS score of 0 to 7 represents "severe cognitive impairment.") No other mental capacity assessments were performed. In May 2014, Mrs. Rayhons's physician determined that because of her cognitive decline she could not consent to sexual intimacy with her husband and so advised Mr. Rayhons.

A week after being told he could not be sexually intimate with his wife, Mr. Rayons visited his wife. After he left, Mrs. Rayhons's roommate notified the staff that she heard noises that sounded like sex from behind the privacy curtain in the semiprivate room. The facility called the police who later determined that Mr. Rayhons's semen was on Mrs. Rayhons's sheets and quilt. He was arrested and charged with third-degree sexual abuse — a felony. If convicted, he likely would have spent the rest of his life in jail.

Both the prosecution and the defense had expert medical witnesses at the trial. The prosecution's medical experts (the attending physician and a neurological expert) testified that Mrs. Rayhons could not give consent. The defense expert, who was a family physician with a specialization in geriatrics and memory, testified that Mrs. Rayons could consent to sexual intimacy with her husband. The defense medical expert testified, in part, that "to rely on a BIMS score to assess whether a person is capable of or should be allowed to have sexual contact would be a medical mistake" (trial transcript).

There were no behavioral changes or visible signs of trauma after each of Mr. Rayhons's visits. To the contrary, there was evidence that Mrs. Rayhons enjoyed visits by her husband. After the landmark trial, the jury returned a verdict of "not guilty."

As demonstrated by *Iowa v. Rayhons*, determining whether a resident has decision-making capacity (DMC) is the central concern. Compounding the difficulty in making an appropriate determination is the fact that DMC can vary from day to day or even within a single day, as we sometimes see with sundowning in the context of dementia. So what can a facility do to avoid resident abuse while protecting a resident's rights?

Determining DMC

State laws vary on the legal definition of both consent and capacity. Further, there is no universally accepted measure for determining DMC. However, there are useful evidence-based guidelines. For example, AMDA – The Society for Post-Acute and Long-Term Care Medicine's 2016 white paper "Capacity for Sexual Consent in Dementia in Long-Term Care" (March 19, 2016, https://bit.ly/AMDAWP319). Likewise, the American Psychological Association together with the American Bar Association has published *Assessment of Older Adults With Diminished Capacity: A Handbook for Psychologists* (2008, https://bit.ly/3Neu4Xz). *Caring for the Ages* (2023;24[1]:16) has also published on determining decisional capacity.

All clinically relevant information should be considered when assessing DMC. Apart from consulting with a geriatric psychiatrist or geriatric psychologist, which may represent the gold standard, all information from the interdisciplinary team — including the social worker, nurses, attending physician, advanced practice providers, family members, chaplain — and anyone with useful information should be considered.

Notably, an assessment of someone's cognitive ability to consent to sexual intimacy is a dynamic process and not "one and done." As health care providers know, DMC may wax and wane depending on a host of factors. Thus, it is prudent to repeat a capacity assessment whenever there is a significant change in clinical condition or another reason to suspect the need for reassessment.

Karl Steinberg, MD, CMD, HMDC, a longtime nursing home medical director and bioethics consultant, recommends taking an individualized approach to DMC assessments and any decision to allow or prohibit sexual contact, including weighing the potential risks or harms of sexual activity against the benefits. This may vary depending on the specific types of physical intimacy being contemplated, the past relationship between participants, and a host of other factors. "Protection of vulnerable residents from harm is crucial, but being overly restrictive of physical intimacy can deprive residents of what may be one of the few pleasures they can still enjoy," Dr. Steinberg says. "Patients with significant dementia may clearly show their desire for sexual contact and their enjoyment of it — even if they may not be able to consent to it using traditional bioethical criteria. And by seeking out, or even just assenting, to an activity that is unlikely to cause harm and that can provide pleasure, they may be considered to possess DMC for this particular decision."

CMS Regulatory Approach and Guidance

The Centers for Medicare & Medicaid Services has promulgated federal regulations and provided guidance to surveyors regarding a resident's right to sexual expression as well as sexual abuse. For instance, nonconsensual sexual contact of any kind is defined as "sexual abuse" and must be reported (42 C.F.R. § 483.5). According to the CMS *State Operations Manual* (SOM) – Appendix PP (https://go.cms.gov/2I3aevU):

> "Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with State law, if applicable. The facility's policies, procedures and protocols, should identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded."

The SOM also refers readers to 42 CFR §483.10(f) [F561] "for concerns related to the resident's right to self-determination," and 42 CFR §483.10(b)(3)-(7) [F551] "for concerns related to the exercise of the resident's rights by the resident representative."

Proactive Approach

An ounce of prevention is worth a pound of cure. One of the most proactive and critical measures a facility can implement is to develop comprehensive and appropriate policies and procedures. One-size-fits-all and cookie-cutter approaches are not particularly helpful. One of the earliest and most effective policies was developed by the Hebrew Home of Riverdale in New York, revised in 2013 ("Policies and Procedures Concerning Sexual Expression," https://bit.ly/3ICBqRW). That policy may serve as a template for facilities to tailor a policy that meets their individualized needs.

A 2016 survey of nursing home policies on sexual expression underscored the importance of a coherent and comprehensive policy. The authors found that "issues related to sexual activity in [nursing home] residents are quite prevalent, however, the rates of policies related to sexual activity are low and the policies and restrictions are not uniform." The authors recommend that nursing homes have policies that are "communicated to residents and their families as part of an admission package" in order to "enable residents to engage in sexual activity with understanding and support rather than hiding" (*J Am Med Dir Assoc* 2016;17:71–74).

Recommendations

- Develop and implement an appropriate policy and procedure (and revise as necessary).
- Educate all involved staff regarding residents' rights and residents' safety, including same-sex couples.
- Involve the facility's quality assurance and performance improvement (QAPI) program, quality assessment and assurance (QAA) committee, and ethics program.
- Gather input from the interdisciplinary team.
- Develop a care plan and revise accordingly.
- Engage an expert, such as a geriatric psychiatrist or geriatric psychologist.
- Inform and engage the state's long-term care ombudsman, as appropriate.

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that overtook my resident's face, a smile that continued even as tears spilled out of each of our eyes, offering healing and renewal. And the lesson I learned then was that happiness is medicinal, joy is contagious, and being your true self brings both.

I thank you for your question!

Dr. Sanders-Cepeda is a geriatrician and Certified Medical Director who has focused her career on geriatric care across the post-acute and long-term care continuum.

Older Adults Are at Growing Risk for Sexually Transmitted Infections

By Joanne Kaldy

When older adults are sexually active, they are at risk for sexually transmitted infections (STIs). In fact, according to the Centers for Disease Control and Prevention (CDC), in the age 65-plus population STIs have more than doubled in the last decade. Post-acute and long-term care practitioners and staff need to know what signs and symptoms to watch for, how to prevent STIs in their residents, how to treat them when they happen, and how to talk to residents and families about this sensitive topic.

Two common STIs in this population, said Casey Rust, MD, a Florida-based geriatrician, are gonorrhea and chlamydia, and the numbers have been steadily on the rise over the past decade. According to the CDC, rates for chlamydia in adults over 65 increased from 1,064 cases in 2011 to 2,780 in 2021, and gonorrhea rates have jumped from 587 cases in 2011 to 3,189 in 2021 (see the CDC's Atlas Plus Charts: https://bit.ly/42K0yNZ). However, sexually active older adults may also be at risk for syphilis, genital herpes, hepatitis B, human immunodeficiency virus (HIV) infection, genital warts, and trichomoniasis. Dr. Rust noted that some STIs are more prevalent in different regions of the country. "It's important to know what STIs are common in your region. Staff need to have this information and understand the risks of STIs and the fact that older adults do have sex."

There are several factors contributing to the growing rate of STIs in older adults. One is the popularity and relative availability of drugs to treat erectile dysfunction, as well as topical estrogen and other products that enable postmenopausal women to enjoy sex longer. Older adults also have more opportunities to make connections through online dating sites and social groups.

The Risks Are Real

Even if they are sexually active, older adults may not see themselves as being at risk for STIs. Safe sex education didn't become prevalent until the 1980s when the HIV/AIDS epidemic started. As a result, they may not realize all the STIs that they are at risk for, and they might think of condoms as something people use to prevent pregnancy, said Dr. Rust.

If residents are sexually active, they — as well as staff — need to know the signs and symptoms. These include: genitals sores or bumps; pain or burning on urination; vaginal discharge or bleeding; pain during sex; sore, swollen lymph nodes, especially in the groin; lower abdominal pain; rash; fever. Many of these could be signs of other conditions besides STIs, so it is important to know if a resident is sexually active. "It is helpful to talk to residents about their sexual history on admission and use that opportunity to talk about safe sex and risk of STIs," said Dr. Rust. At the same time, practitioners need to have STIs on their radar if a resident has any of these symptoms.

Residents need to be aware of ways to prevent STIs. These include using a new latex condom or dental dam each time they have intercourse or oral sex. They should be informed about lubricants that can make intercourse more comfortable; however, they need to avoid oil-based lubricants, such as petroleum jelly, when using condoms or dental dams. Encourage residents to talk to their sexual partners about safe sex and the importance of using protection.

It will be beneficial to make condoms and dental dams available to residents and provide these in a nonjudgmental way. They may not be able to get out to a store to buy their own protection and may be too embarrassed to ask family or friends to buy them.

Two FDA-approved combination drugs can reduce the risk of HIV infection in high-risk individuals: emtricitabine plus tenofovir disoproxil fumarate (Truvada) and emtricitabine plus tenofovir alafenamide fumarate (Descovy). Individuals must be tested for HIV before being prescribed these drugs and then tested again every three months as long as they are taking them. For the Truvada regimen, practitioners also must test kidney function before prescribing and every six months. Individuals with hepatitis B should be evaluated by an infectious disease specialist before receiving a Truvada prescription.

Diagnosis and Treatment

Residents may not be inclined to readily offer information about their sexual activities. However, these conversations can help determine if they may have an STI or are at risk. "When we approach these [conversations] with respect and compassion, we can gain some important information. For instance, we can find out if they have pain or other difficulties during sex," said Dr. Rust. Not only can this help identify when someone has an STI, but it may point to the need to assess them for other conditions such as diabetes or depression.

If a resident has signs of an STI, blood tests, urine samples, or fluid samples can identify specific STIs. "While screening for some infections such as HIV should be offered to all adults, screening for other STIs is based on risk factors and symptoms. Current sexual activity as well as history of STIs should be considered," Dr. Rust said.

Treatments for STIs are similar for older adults and younger patients alike. For example, gonorrhea, syphilis, and chlamydia can all be treated with antibiotics. However, Dr. Rust said, "we need to be mindful of the potential side effects or reactions to antibiotics." Chronic kidney disease is common in older adults, so it will be important to check kidney function to determine what antibiotic to use. It also is important to weigh the risk for *Clostridioides difficile* infection as a complication of antibiotic therapy.

Ensure Inclusivity

The care team needs to put aside their assumptions about sexuality and be sensitive to LGBTQ+ residents. "Start all conversations about sexual history and activity with a general discussion and a nonjudgmental demeanor. You can ask what gender or genders they are having sex with and stress that this is a question you ask everyone," said Dr. Rust. Make it clear that this information will help you provide the best possible care and ensure their quality of life.

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- Recognize the guidance in the CMS SOM and understand what surveyors will look for.
- Provide a copy of the policy and procedure at the time of admission.
- Consider posting the policy and procedure on the facility's website.
- Document *all* relevant information.

Conclusion

The literature has demonstrated the importance of recognizing sexual expression in older adults, especially those with cognitive impairment. Respecting residents' rights along with protecting them is not only governed by federal and state law but is also an ethical imperative. Planning ahead can avoid tragic situations like the *Rayhons* case.

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