STATE OF MICHIGAN

COURT OF APPEALS

PEOPLE OF THE STATE OF MICHIGAN, Plaintiff-Appellant,	FOR PUBLICATION August 5, 2008 9:00 a.m.
v	
ELIZABETH ANN EDENSTROM, Defendant-Appellee.	No. 277291 Wayne Circuit Court LC No. 06-100037

Before: Zahra, P.J., and Cavanagh and Jansen, JJ.

CAVANAGH, J.

The prosecution appeals by delayed leave granted an order dismissing its complaint charging defendant with violating MCL 333.21771(2), which requires a nursing home administrator to report certain incidents to state authorities. We affirm.

On December 18, 2004, William Devine, an oxygen-dependent resident of Rivergate Health Care Center, suffered burn injuries while attempting to smoke a cigarette. Devine was in a designated smoking area of the nursing home, wearing his nasal cannula that was hooked up to an oxygen tank. The certified nursing assistant who was helping him turned off the oxygen supply and proceeded to light Devine's cigarette. Residual oxygen in his nasal cannula tubing ignited, causing Devine to suffer burns to his hands and face, as well as smoke inhalation. The nursing assistant later indicated that she did not know that nasal cannula tubing could contain oxygen after the oxygen tank was turned off.

Pursuant to MCL 333.21771, a nursing home administrator is required to report to state authorities any physical, mental, or emotional abuse, mistreatment, or harmful neglect of a patient. Here, Rivergate's administrator—defendant—conducted an investigation into the incident and concluded that the incident was an "accident" and, thus, reporting was not required under the statute. Devine's family member, however, reported the incident to state authorities and an investigation followed.

Defendant was subsequently charged with the misdemeanor offense of failing to report the incident to state authorities as required by MCL 333.21771(2). Defendant moved to dismiss the charge, arguing that (1) this "accident" was not within the contemplation of the statute's reporting requirements, and (2) the statute does not impose a criminal penalty. The prosecution countered that (1) the circumstances showed, at least, recklessness that warranted reporting, and (2) the statutory "catch-all" provision provided that violations of the public health code for which

a penalty is not otherwise provided are punishable as misdemeanors. The district court agreed with the prosecution and denied defendant's motion to dismiss.

Defendant appealed to the circuit court. The same arguments were presented. The court agreed with defendant, holding

> This Court has reviewed the issues presented de novo. And section 21771(1) states that, "A licensee, nursing home administrator or employee of a nursing home shall not physically, mentally or emotionally abuse, mistreat or harmfully neglect a patient."
>
> This Court is adopting appellant's argument. This Court believes that the reporting statute applies only to one's awareness of willful abuse, mistreatment or neglect, not to accidents.
>
> This Court cannot expand the definition of the conduct, which constitutes a crime, because criminal statutes must be strictly construed under Michigan laws.
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> Since this Court believes that the accident that occurred here was not meant to be considered harmful neglect or abuse and neglect [sic] reporting purposes, this Court feels that reporting was not required under the circumstances. Therefore, this Court is reversing the order entered by the Twenty-seventh District Court denying [defendant's] motion to dismiss the complaint. This Court rules in favor of the appellant.

This delayed application for leave to appeal followed, and was granted. See *People v Edenstrom*, unpublished order of the Court of Appeals, entered August 16, 2007 (Docket No. 277291).

The prosecution argues on appeal that the circuit court misconstrued MCL 333.21771, reading into it a "willful" element that is not required by the statute. We review de novo this issue of statutory interpretation. *Bloomfield Charter Twp v Oakland Co Clerk*, 253 Mich App 1, 9; 654 NW2d 610 (2002).

MCL 333.21771 provides:

> (1) A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a patient.
>
> (2) A nursing home employee who becomes aware of an act prohibited by this section immediately shall report the matter to the nursing home administrator or nursing director. A nursing home administrator or nursing director who becomes aware of an act prohibited by this section immediately shall report the matter by telephone to the department of public health, which in turn shall notify the department of social services.

The issue here is whether defendant, as nursing home administrator, was required to report the incident involving Devine. MCL 333.21771(2) requires the nursing home administrator to report "an act prohibited by this section immediately . . . ." The acts prohibited by the section are physical, mental, or emotional abuse, mistreatment, and harmful neglect of a nursing home patient. MCL 333.21771(1). The prosecution contends that the nursing assistant's conduct with regard to Devine constituted harmful neglect within the contemplation of the statute; thus, the nursing home administrator—defendant—was required to immediately report the matter.

Whether a defendant's alleged conduct falls within the scope of a statute presents a question of law that is reviewed de novo. See *People v Thomas*, 438 Mich 448, 452; 475 NW2d 288 (1991); *People v Rutledge*, 250 Mich App 1, 4; 645 NW2d 333 (2002). In reviewing questions of statutory construction our purpose is to discern and give effect to the Legislature's intent. *Echelon Homes, LLC v Carter Lumber Co*, 472 Mich 192, 196; 694 NW2d 544 (2005). We first turn to the plain language of the statute; if the language is unambiguous, no judicial construction is required or permitted and the statute must be enforced as written. *Id*., quoting *People v Morey*, 461 Mich 325, 330; 603 NW2d 250 (1999). And, pursuant to MCL 8.3a,

> All words and phrases shall be construed and understood according to the common and approved usage of the language; but technical words and phrases, and such as may have acquired a peculiar and appropriate meaning in the law, shall be construed and understood according to such peculiar and appropriate meaning.

The phrase "harmfully neglect" is not defined by MCL 333.21771. The prosecution urges us to adopt dictionary definitions of the words. If the legislative intent cannot be determined from the statute itself, a court may consult dictionary definitions for guidance in determining the plain and ordinary meaning of words, i.e., "the common and approved usage of the language." MCL 8.3a; see, also, *Koontz v Ameritech Services, Inc*, 466 Mich 304, 312; 645 NW2d 34 (2002). Were we to agree with the prosecution, we would turn to the dictionary definition of "neglect" and find that its definitions include: "1. to pay no attention or too little attention to; disregard or slight. 2. to be remiss in the care of . . . . 3. to omit, as through indifference or carelessness . . . . 4. to fail to carry out or perform." *Random House Webster's College Dictionary* (1977).

But, as proposed by defendant, our inclination is that the phrase "harmfully neglect," as it is used in MCL 333.21771(1), has acquired a peculiar and appropriate meaning in the law. That meaning has primarily been prescribed by the Department of Community Health,[1] the entity generally responsible for the administration of nursing homes. MCL 333.21741(1) provides:

> The department of public health, after seeking advice and consultation from the department of social services, appropriate consumer and professional organizations, and concerned agencies, shall promulgate rules to implement and administer this part.

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[1] Formerly known as the Department of Public Health.

The "part" referred to in MCL 333.21741(1) is Part 217 and it pertains to nursing homes. MCL 333.21771 is obviously a section within Part 217. In an apparent effort to accomplish the delegated task, the Bureau of Health Systems (Bureau) compiled a complaint investigation manual for long term care complaints and facility reported incidents called the "Complaint and Facility Reported Incident Manual." Recognizing that the pertinent terms—like abuse, mistreat, and neglect—are used but not defined by the applicable statutes, Section 3300 of the Manual "sets forth definitions that meet the intent of these multiple legal bases."

Section 3320 of the Manual states as follows:

> *Neglect* means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The source of this definition is 42 CFR 488.301. The Public Health Code does not define the term *harmfully neglect* used in 21771(1). By definition, neglect is harmful, so the federal definition is adopted for both state and federal purposes.
>
> Please note that by definition a particular event is either abuse or neglect, not both.
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> Basically, neglect involves the failure of a staff person to carry out his/her duties in regard to a resident. In theory, <u>any</u> failure to provide required services of <u>any</u> kind for <u>any</u> reason could be considered neglect. However, citations for neglect are normally issued only in cases where there is significant actual harm resulting from a failure to act in the presence of the knowledge of what should be done and the capability to provide the required services. Such cases may include a failure to follow a standard of practice. Even if neglect is not cited, citations are issued against the facility for the specific care issues involved.

It is well settled that agencies are allowed "to interpret the statutes they are bound to administer and enforce." *Clonlara, Inc v State Bd of Ed*, 442 Mich 230, 240; 501 NW2d 88 (1993). And this proffered definition and explanation is not only consistent with the dictionary definition, but it is consistent with the definition of "neglect" under the Social Welfare Act, MCL 400.11 *et seq*., which states, in part, that "[n]eglect includes the failure to provide adequate food, clothing, shelter, and medical care." MCL 400.11(d).

Defendant, as the nursing home's administrator, was required to follow the rules promulgated by the Bureau as set forth in their Manual. Thus, she was to immediately report any instance of harmful neglect. Defendant's investigation into the Devine incident revealed that the nursing assistant lit Devine's cigarette not knowing that oxygen could remain in the nasal cannula tubing after the oxygen tank is turned off. Defendant concluded that the incident was an accident. According to defendant's interpretation of the reporting provision of the Manual, this incident was not reportable because it was not the result of a willful failure to provide treatment. Defendant understood that "harmful neglect" meant knowing or intentional neglect as relates to medical treatment, not accidents. Thus, defendant did not report this incident under MCL 333.21771(2).

First, we consider defendant's conclusion that the nursing assistant's conduct did not constitute harmful neglect. All of the record evidence indicates that the nursing assistant turned

off the oxygen tank and then lit Devine's cigarette. She did not remove Devine's nasal cannula before doing so because she did not know that oxygen could remain in the nasal cannula tubing after the oxygen tank is turned off. The evidence also reveals that the nursing assistant followed the smoking policy that was in place at the time—that policy did not include the removal of nasal cannula before lighting a resident's cigarette. And, there is no evidence that the nursing assistant was provided an in-service or educational materials from the facility related to smoking while receiving oxygen therapy or wearing a nasal cannula. In other words, the nursing assistant did not fail to carry out her duties in regard to Devine; she did what she knew to do. She did not fail "to act in the presence of the knowledge of what should be done and the capability to provide the required service." The evidence clearly showed that the nursing assistant did not harmfully neglect Devine as that phrase is used in the statutory provision.

This conclusion is buttressed by the provisions in the Manual that explain what is meant by "neglect." The Manual states:

- A resident has been neglected whenever all of the following conditions are satisfied:
  - ► The facility fails to provide or arrange for medical, dental, nursing, dietary, physical therapy, pharmacy, habilitation, psychological, speech, audiological or other treatments or services to the resident in question; and
  - ► The facility's failure to provide these treatments or services is either intentional or the result of carelessness; and
  - ► The failure to provide these treatments or services, results in a deterioration of the resident's physical, mental or emotional condition.

- Examples of Neglect:
  The following actions or omissions constitute neglect whenever they result in a noticeable deterioration of the resident's physical, mental or emotional condition:
  - ► Failure to carry out a physician's order . . . .
  - ► Failure to carry out nursing, treatment or individual resident care plans.
  - ► Failure to notify a resident's attending physician and other responsible persons in the event of an incident involving that resident.
  - ► Failure to notify a resident's attending physician and other responsible persons in the event of a significant change in that resident's physical, mental or emotional condition.
  - ► Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals.
  - ► Failure to adequately supervise the whereabouts and/or activities of a resident.
  - ► Failure to take precautionary measures that have been ordered . . . .
  - ► Refusal or failure to provide any service to the resident for the purpose of punishing, disciplining or retaliation.
  - ► Allowing the physical environment to deteriorate . . . .
  - ► Leaving a resident lying in feces or urine soaked linens for an extended period of time.
  - ► Leaving a resident restrained in other than an immediate emergency, without a physician's order, solely for an employee's own convenience.

The examples of neglect cited in the Manual persuade us that the neglect need not be willful, as defendant argues and the circuit court appeared to conclude. To the contrary, the neglect can be unintentional. The act or omission may be, for example, in disregard or in violation of specific orders or care plans, a duty, or a resident's rights. The situations cited in the Manual are not exhaustive, they are merely "examples." The focus of the inquiry is on the act or omission, as well as the surrounding circumstances—a point made more clear with an example.

A resident lays in urine soaked bed linens for seven hours and a severe pressure ulcer develops. The nursing assistant merely got busy and lost track of time. She knew that leaving a resident in that condition was unacceptable and she did not intend to do it. It just happened. It was an accident. The nursing assistant's conduct constituted harmful neglect, reportable under MCL 333.21771(2). In contrast, in this case the nursing assistant's action did not constitute harmful neglect—she performed the duties she was assigned to perform, in the manner that she was trained to perform them. Contrary to the dissenting opinion, that the nursing home had a poor or improper smoking policy in place at the time of this incident does not change our opinion with respect to the nursing assistant's own actions. We believe that "the negligence of the Rivergate Care Center," as it is referred to by the dissent, is a different issue than the one before us, i.e., what constitutes "harmful neglect" by a nursing home employee. Thus, we agree with defendant's conclusion on this issue, although we reject defendant's reasoning.

Second, we turn to defendant's decision not to report this incident. This action against defendant resulted from her failure to report this incident to state authorities as mandated by MCL 333.21771(2). Section 3410 of the Manual sets forth the Bureau's interpretation of that statute as follows:

> Section 21771 requires *immediate* reporting when the facility becomes *aware of a prohibited act*. The federal requirement requires reporting *alleged* violations. In both cases the facility must first screen incidents, observations, and other problematic or unusual events reported by employees to determine if they potentially involved any alleged acts, which could meet the definition of abuse if they were substantiated. The facility must investigate the alleged act or incident. The facility must make a preliminary judgment regarding the likely credibility of a reported incident, i.e., abuse, neglect, or misappropriation and immediately report abuse, neglect, or misappropriation. Only reports that meet these tests need to be reported.

Section 5241 of the Manual sets forth the Bureau's rules related to the investigation of incidents as follows:

> Each long term care facility must review any and all situations or incidents in which a resident may have suffered physical or other harm for reasons which are unknown, unclear or not adequately explained. If, during the course of that review, the facility finds reason to believe that abuse, neglect, or misappropriation was or is suspected to have been the cause of that harm, the incident must be reported to the Bureau.

> A nursing home administrator or nursing director is first expected to immediately conduct a thorough in-house investigation to determine what happened and do the following:
>
> - If it is determined by a conclusive investigation that the incident did not occur or was not abuse, neglect, or misappropriation, a detailed incident report and the investigation findings must be filed in the facility. It is not necessary to notify the Bureau in those cases.
>
> - If it is determined that the abusive practices did occur or are still suspected then the nursing home is required to notify the Bureau as described below.

Section 5243 of the Manual repeats that:

> Incidents do not need to be reported to the Bureau if it is determined by a conclusive facility investigation that the incident did not occur or was not abuse, neglect, or misappropriation. A detailed incident report and the investigation findings must be filed in the facility for potential review by Bureau surveyors at surveys or other visits.

Again, Section 5272 of the Manual provides:

> The Bureau cites facilities that fail to report immediately (as defined above) even if they voluntarily report later.
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> **EXCEPTION:** As noted above, facilities which conduct a thorough in-house investigation and determine that the incident was not abuse, neglect, or misappropriation are required to maintain a detailed report or accident report on file in the facility and it is not necessary to notify the Bureau. If investigation determines that the incident was in fact abuse, neglect, or misappropriation, the facility is not cited by the Bureau for failure to report if it is determined that the facility conducted a thorough investigation and made a good faith, informed judgment that the incident was not abuse, neglect, or misappropriation.

Here, defendant contends that she did not report this incident to the Bureau because her conclusive investigation resulted in a good faith determination that the incident was not abuse, neglect, or misappropriation—it was an accident. As discussed above, we agree with defendant that the incident did not constitute harmful neglect for which reporting was required under MCL 333.21771(2). We also agree with defendant that the Manual clearly requires that the nursing home administrator exercise his or her judgment in determining whether an incident must be reported—not all incidents that result in harm or injury to a resident are required to be reported immediately to the Bureau. The Manual repeatedly makes that clear. Thus we disagree with the dissenting opinion's position that the nursing administrator must immediately report, without the benefit of any investigation, any and all incidents that occur in a nursing home.

However, we reject defendant's suggestion, as well as the circuit court's apparent conclusion, that those incidents that can be characterized as "accidents" need not be reported. The term "accident" is too subjective and nebulous. So-called "accidents" that may be the result

of harmful neglect as set forth in the Manual are to be reported immediately. We also reject defendant's claim that only if she "became aware of outright physical, mental or emotional abuse, mistreatment or harmful neglect is the statute's reporting requirement triggered." The term "outright" implies an element of absolute knowledge of prohibited behavior that is not consistent with the Manual's reporting requirement. To the contrary, Section 5241 of the Manual states that if there is "reason to believe that abuse, neglect, or misappropriation was or is suspected to have been the cause of that harm, the incident must be reported to the Bureau." Accordingly, the Bureau has interpreted the reporting requirement of MCL 333.21771(2) broadly, which is consistent with sound public policy—overreporting is more desirable than underreporting.

In summary, in light of the facts and circumstances, defendant's conduct—her failure to report the incident—did not fall within the scope of MCL 333.21771(2). See *Thomas*, *supra*. It is clear that the nursing assistant's act or omission with regard to the lighting of Devine's cigarette did not constitute harmful neglect within the contemplation of the statute. Thus, we affirm the circuit court's dismissal of this action. To the extent the circuit court interpreted a "willful" element in MCL 333.21771, that interpretation is rejected, as is the circuit court's holding that this reporting statute does not apply to "accidents." In light of our resolution of this issue, we need not consider whether a violation of MCL 333.21771(2) is punishable under MCL 333.1299.

Affirmed.

/s/ Mark J. Cavanagh
/s/ Kathleen Jansen