LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
August 2009 Volume 17 Number 8

Dementia Care: Court Finds Patient Abuse, Upholds Penalties Against Nursing Facility.

The eighty-seven year-old resident suffered from dementia and had a history of insomnia and falling.

After he fell and fractured his hip his physician ordered a soft safety belt to help restrain him when he was in his wheelchair.

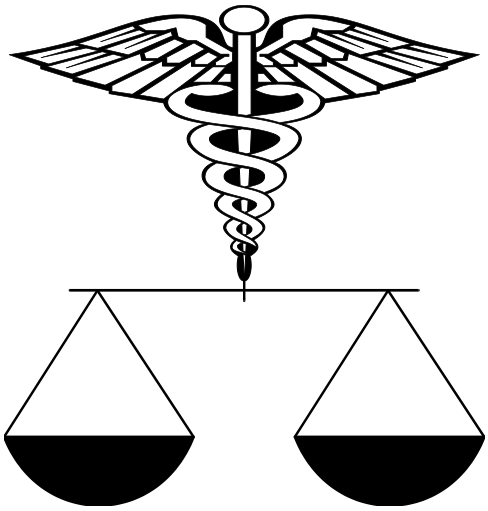
One early morning when he was still awake and sitting in his wheelchair at the nurses station he removed the soft waist restraint belt keeping him in the wheelchair and became combative with the two nurses at the station.

The nurses tried to prevent him from falling and tried to persuade him to give up the waist restraint. They called another nursing assistant to come and assist them because the one who was with the resident was physically too small to handle him.

While attempting to subdue the resident the nursing assistant grabbed the resident's right arm and tried to get the restraint out of his left hand.

After the resident pulled his arm away and refused to release the restraint one of the nurses asked the nursing assistant to let go of the resident's arm and then managed to persuade the resident to give up the restraint.

The nursing assistant then reportedly grabbed the resident's arms roughly while the nurses re-applied the restraint.



Federal regulations define abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Physical abuse is presumed to have occurred when unjustifiable contact with a resident results in injury or harm to the resident.

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After the restraint was back in place the nursing assistant released the resident's arms, but the resident then removed his restraint for a second time.

This time when the nursing assistant tried to grab the resident's arms the resident started swinging at him. At that point the nursing assistant grabbed both of the resident's wrists and would not let go.

One of the nurses then suggested that the resident needed to go to bed, as it was past midnight.

The nursing assistant angrily answered, "He's not going to bed," and then wheeled the resident to his room to clean and change him because he had become incontinent either before or during the incident.

About ten minutes later the nursing assistant returned with the resident, who had been cleaned and changed.

The resident appeared upset and his eyes were watery and his lips were quivering. He pointed to his wrist and said to the nurse, "You broke my heart."

The nurse observed redness and edema on the resident's wrists three to four inches up his forearm, as well as redness on his hand. The resident told the nurse that it hurt, and when she touched his wrist he pulled away and said "ouch."

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Dementia Care: Court Upholds Civil Monetary Penalties Against Nursing Facility (Continued).

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When the nurse returned the next morning the resident showed her his right arm, which had dark bruises on the wrist.

The nurse had begun preparing a progress note on the day of the incident, a Friday, and completed it the following Monday.

The nursing assistant continued to work over the weekend and provided care to multiple residents, including this resident, without further incident.

The facility's director of nursing was not contacted on the date of the incident but only learned of it when she came in on that Monday and reviewed the weekend incident log.

That same day she began a routine investigation into the incident, starting with the nurse's progress note.

In a follow-up interview with the state survey inspector she later indicated that had she been on duty at the time of the incident, the nursing assistant would have been suspended immediately.

Instead, the nursing assistant was suspended on Tuesday and terminated later that week.

Facility Cited for Multiple Violations Of Federal Regulations For Nursing Facilities

The nursing home was cited for violating 42 C.F.R. § 483.13(b) which prohibits abuse of residents. Facilities participating in the Medicare and Medicaid programs are forbidden from using verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion.

Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

Interpretive guidelines state that a resident has been physically abused when

(1) Physical contact was made;

(2) The physical contact was intentional or careless;

(3) Physical harm resulted or physical injury, pain, or death to the resident was a likely outcome; and

(4) There was a lack of reasonable justification for the contact.

The nursing assistant handled the elderly resident angrily. What happened was not accidental and it was not necessary in providing care. It was intentional and retaliatory.

Physical contact while providing care, comfort or assistance to a resident is permissible when the type of contact and the amount of force used are absolutely necessary in order to provide care, according to the US Department of Health and Human Services State Operations Manual.

Physical contact that occurs in the course of attempting to restrain a resident's behavior in an emergency is permissible if both the type of contact involved and the amount of force used are reasonably necessary to prevent the resident from injuring himself or herself, injuring anther person or damaging property.

Squeezing any part of a resident's body is a specific example of potentially abusive treatment.

The nurse involved in the incident, as required by law, wrote a candid and detailed progress note which reflected accurately what really happened.

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The nursing home was also cited for violating 42 C.F.R. § 483.13(c)(2) which requires facilities to ensure that all incidents involving mistreatment are reported to the administrator of the facility and to officials in accordance with State law.

This section of Federal regulations also requires facilities promptly to investigate all allegations of abuse and the results of all investigations must be reported to the administrator or the administrator's designated representative and to officials in accordance with State law within 5 working days of the incident.

According to the court, it was irrelevant that the facility's director of nursing did not learn of the incident for two days. Federal law requires a report within five days of the incident. The time lag between the incident occurring and the director of nursing learning of the incident does not extend the Federal deadline.

Federal standards also require facilities to report incidents of abuse to state authorities within the time frame specified by state law. The court noted that the deadline for reporting abuse under state law (in North Carolina) begins to run when the health care facility itself, not any specified person, learns of abuse. In this case the facility learned of abuse when the resident himself alerted the nurse to the fact he had been injured.

In addition to reporting of incidents in compliance with Federal guidelines a facility is also required to set up effective policies for reporting of such incidents. Failure to implement such policies is a separate and distinct violation of Federal standards above and beyond what occurs in an incident and when and how it is reported.

Pattern of Abuse

The court endorsed the maximum civil monetary penalties allowed by law, on the grounds that a pattern of abuse and of inadequate response to abuse existed at the facility.

The nursing assistant continued working and was not dealt with promptly, nor were procedures in effect to deal with an alleged abuser promptly. Other incidents of less serious abuse had occurred. **Beverly Healthcare v. Leavitt, 2009 WL 2171235 (4th Cir., July 22, 2009).**